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Reflections from Group Therapy for Eating Disorders

by

Michelle K. Russell

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ABSTRACT

Researchers suggest that group psychotherapy, regardless of the paradigm used, is the treatment of choice for people with eating disorders. This study attempts to understand themes related to recovery in group therapy for women with eating disorders. Of particular interest is the influence of reflecting teams on group therapy. Inquiry focuses on emerging themes and shifts in content over a 14-week psychotherapy group with 6 women. Grounded theory was the methodology used to extract themes from the data.

The basic psychosocial process was identified as the safety of the group. Movement of the group involved a shift in focus from intrapersonal matters such as eating and weight to an interpersonal focus on relationships. Phase I was identified as the influence of the eating disorder on life and relationships and Phase II was important factors in overcoming an eating disorder. The categories that emerged at each phase are discussed as well as implications for counseling.

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CHAPTER 1: INTRODUCTION

Introduction

There is a vast literature on eating disorder etiology, maintenance, and treatment. Eating disorders are characterized by severe disturbances in eating behavior (Stoylen & Laberg, 1990). Depending on the model to which one adheres, many other characteristics of people struggling with eating disorders can be identified. The medical model separates the individual from society and uses specific diagnostic criteria to define anorexia and bulimia (DSM-IV; American Psychiatric Association, 1994). As early as 1873, anorexia was considered a psychiatric syndrome and traditionally labeled intrapsychic in nature (Epstein, 1990). Recently, a sociocultural model has emerged to include society and culture in the overall conceptualization of eating disorders. A feminist framework places women in society on a continuum where body preoccupation exists on the less extreme end and anorexia and bulimia toward the more extreme (Brown, 1993). The feminist lens allows a view of the similarities between people at all points on the continuum. Finally, the introduction of a relational model of self-development (Gilligan, 1982) adds much needed information about female development to the conceptualization of eating disorders, particularly as they usually affect women and girls in our society.

There are as many treatment modalities in the literature as there are models of conceptualization. Recent trends that consider sociocultural and historical contexts in models of eating disorders are reflected in the development of treatment protocols. There seems to be parallel movement from impersonal and authoritarian modes of treatment to more empowering, woman-centered treatments administered with consideration of the

larger context. This evolution had lead to group therapy being the treatment of choice for women with eating disorders (Edmands, 1986; Kuba & Hanchey, 1991; Riess & Rutan, 1992).

Few controlled studies exist to corroborate the conclusion that group therapy is the most effective treatment for eating disorders. Caution must be exercised when determining the variables involved in the change process (McKisack & Waller, 1996). One special type of group, a reflecting team, has potential to be useful by adding new perspectives and unique contributions. However, the use of reflecting teams has not been evaluated in a group context in the treatment of eating disorders. The process of reflecting includes watching the group behind a one-way mirror and then reflecting to the group and therapist(s) what they have observed (Anderson, 1987). Research suggests that reflecting teams can be useful for their contribution of multiple perspectives and demonstration of changing ideas through discussion and negotiation (Biever & Gardner, 1995). Although not supported by research, there are a number of ways in which the reflecting team could potentially be additive to the group interaction, including combating isolation, modeling healthy relationships, pointing out dichotomous thinking, processing the issue of control, being less than perfect, and modeling emotional expression.

The Current Study

It is important to recognize and understand the relationship between the model of conceptualization and the kind of treatment under investigation. This author's perspective is the feminist model where the eating disorder continuum, ranging from body preoccupation to yo-yo dieting to the extreme end of anorexia and bulimia, provides a

starting place for understanding eating disorders within our current Western society. Past research with eating disorders has focused mostly on standardized test scores to determine the usefulness of treatment. This approach ignores the interaction involved in group counseling and the potential to uncover important themes related to recovery and treatment. It is imperative to build on our current understanding of eating disorders by listening and validating the voices of the people who struggle with eating disorders. Research that is grounded in the experience of the participants not only adds to our knowledge but potentially leads to better treatments.

As the research on reflecting teams is still in its early stages, investigations are needed to consider their therapeutic value. The current study will explore the multidimensional nature of eating disorders by examining the similarities and differences of healing for women in group therapy. Recognizing the link between models and treatment is important in the development of an understanding of eating disorders. First, this study will attempt to study the therapeutic contribution of the reflecting team component by testing the theoretical premises of the themes emerging from the group interaction. Secondly, this study attempts to uncover the themes and ideas from the perspective of women that are important to recovery. Each woman in this psychotherapy group is at a different place on the continuum (that can include weight preoccupation, compulsive exercise, and at the more extreme end, anorexia and bulimia), and it is hoped that by studying the similarities and differences in their experience, that important factors involved in recovery can be uncovered. Comparing the themes that emerge from the

literature with themes uncovered directly from the women in the group itself has the potential to bridge some of the gaps in our understanding of eating disorders.

Overview

The primary goal of this study is to examine the group interaction in order to illuminate important themes related to treatment and recovery of women with eating disorders. An additional goal is to examine the contribution of reflecting teams to group therapy. Chapter 2 provides a review of the literature concerning eating disorders, models of conceptualization for eating disorders, and treatment modalities with a focus on group therapy and reflecting teams. Chapter 3 outlines the research methodology of the study, which was designed to be sensitive to lived and changing experiences of women. Chapter 4 presents the results of the research study. The possible implications of the study for the treatment of eating disorders is provided in Chapter 5.

CHAPTER 2: LITERATURE REVIEW

Literature Review

Eating disorders are conceptualized in the literature from many different perspectives. Five models or conceptualizations of eating disorders will be outlined in this chapter. The medical, traditional, sociocultural, feminist, and relational models offer different perspectives and explanations about eating disorders. The perspective one adheres to affects the treatment modalities chosen. Recently, a shift in the type of treatment considered effective has taken place. Group therapy is often considered the treatment of choice for people with eating disorders. One particular approach to therapy, a reflecting team, has not been studied in use with eating disorder groups. Six themes common in the literature are examined in this chapter including isolation, healthy relationships, dichotomous thinking, control, perfectionism, and emotional expression. Both group therapy dynamics and the potential additive contribution of the reflecting team are studied to theorize about the usefulness of groups as treatment for people struggling with eating disorders.

Eating Disorders

Ninety percent of people struggling with eating disorders are female. (Rolls, Fedoroff & Guthrie, 1991). Reports indicate that the incidence of eating disorders is steadily increasing in the adolescent and adult female population (Cantrell & Ellis, 1991; Powers, 1996). Some estimates state that up to 20% of women are at "high risk" due to subclinical symptoms (Cantrell & Ellis, 1991). Prevalence rates for anorexia and bulimia are not precise due to the secretive nature of these disorders. However, the incidence rates

for anorexia is commonly cited as 1% of the female population while for bulimia the rates vary from 4% to 18% (Dietz, 1990; Klemchuk, Hutchinson & Frank, 1990). The combined prevalence of anorexia and bulimia has recently been estimated as high as 20% for school age children (Phelps & Wilczenski, 1993).

These alarming prevalence statistics may vary somewhat depending on the way eating disorders are conceptualized. Regardless of orientation there is agreement that eating disorders are serious health risks that affect primarily females. There are numerous models of eating disorders. These models are ways in which to organize and make sense of eating disorder etiology, maintenance, and treatment. Essentially models provide accounts of eating disorders from different perspectives and thus the conceptualizations of eating disorders are vast and different. In the following section a number of perspectives about eating disorders will be explored. The models covered in this section include the medical, traditional, sociocultural, feminist and relational models.

The Medical Model

Eating disorders are a prevalent problem in our society, characterized by severe disturbances in eating behavior (Stoylen & Laberg, 1990). In the traditional conceptualization of eating disorders the medical model separates the individual from society and culture. The *Diagnostic and statistical manual of mental disorders, 4th ed.* (DSM-IV; American Psychiatric Association, 1994) defines diagnostic criteria for anorexia nervosa as follows: 1) refusal to maintain normal weight for age and height, 2) intense fear of becoming fat, 3) body image distortion and/or a large part of self worth based on body weight or shape, and, 4) amenorrhea (absence of 3 consecutive menstrual

cycles). For bulimia nervosa the diagnostic criteria outlined in the DSM-IV include: 1) recurrent episodes of binge eating, (eating a large quantity of food in a discrete period of time with a sense of lack of control), 2) purging behavior to prevent weight gain like self-induced vomiting, laxatives, diuretics, enemas, fasting, or excessive exercise, 3) bingeing and purging both occur on average at least twice a week for 3 months, 4) self-evaluation is unduly influenced by body shape and weight and, 5) the disturbance does not occur exclusively during episodes of anorexia nervosa. Finally, another category in the DSM-IV (APA, 1994) called "eating disorder not otherwise specified" includes any disordered eating that does not meet all the criteria for the other classifications of eating disorders.

A Traditional View of Eating Disorders

Traditionally, eating disorders were pathologized as diseases. Anorexia nervosa was first recognized as a distinct psychiatric syndrome around 1873 (Epstein, 1990). Bulimia nervosa was not recognized as distinct from anorexia until more than a century later (de Groot, 1994). Although these discrete categories may be useful in the psychiatric treatment of eating disorders, they are limited in application when the sociopolitical and cultural contexts are considered (White, 1991). It has not been uncommon, however, for medical management and the labeling of mental illness to be used to contain women's suffering (White, 1991). For example, women's dieting and preoccupation with weight are often trivialized without examining how culture may have influenced this pattern of behavior. Medicalization, aided by the power of money, remains a primary treatment, as evidenced by the multi-billion dollar dieting industry (Hesse-Biber, 1996).

Sociocultural Models

Traditionally, explanations of eating disorders have focused on the intrapsychic problems of the individual. More recently, however, "there is increasing sentiment that eating disorders reflect a social illness bound within a sociocultural experience" (Thorton, Leo, & Alberg, 1991). Most current models of eating disorders include sociocultural factors as part of the overall conceptualization of their development and maintenance. The predominant sociocultural factor, usually mentioned in all models of eating disorders, is the present cultural standard of thinness.

The cult of thinness. The cultural definition of woman's beauty has changed since the turn of the century to include thinness. This has been documented (Garner, Garfinkel, Swartz, & Thompson, 1980, cf: Garner & Garfinkel, 1985; Silverstein, Peterson, & Perdue, cf: Irving, 1990) but can also be clearly witnessed through advertisements, television, and magazines which present only images of the "perfect" woman. For instance, Marilyn Monroe, who was idolized in the 1950's, would be considered chubby by today's standards of girlish thinness. Towards the late 1960's the idolized shape changed dramatically to include only thin women like the fashion model Twiggy. That women, historically and presently, try to change their bodies to conform to society's image of beauty has relevance especially in the culture of today because it seems the ideal for women has reached an impossible and unobtainable standard. This notion is empirically validated by a number of studies. Wiseman, Gray, Mosimann, & Ahrens (1992) showed that body weight of Playboy magazine contestants was 13-19% below expected weight for women in that age group. Body measurements, bust size, waist size, and hip size were obtained for Playboy magazine

centrefolds and Miss America contestants between 1979 and 1988. Results indicated that over the 10-year period the majority of the Playboy centrefolds and the Miss America contestants had weights 15% or more below the expected weight for their age and height. Garner et al. (1980, cf: Garner & Garfinkel, 1985) also reported a discrepancy between reality and the media's representation of truth. After examining the Metropolitan Life Insurance Companies policies, Garner et al. (1980, cf: 1985) discovered that the expected weight for women had increased over the last 25 years. This finding is ironic because the study revealed that this rate of increase was inversely proportional to the average weight of Playboy centrefolds. In other words, as average women are increasing in weight, women portrayed in the media are decreasing in weight. This inaccurate portrayal helps create an unrealistic and unattainable ideal of beauty.

Internalized standards of beauty. Barthel (1988) suggests that the unnatural slimness seen today in the media is seen as the natural norm to which women strive to conform. She argues that women have a very finely tuned idea about what is an acceptable body and rapidly internalize the current standard of female beauty. The standard of beauty in our current culture is unattainable for most women (McCarthy, 1990). It is not surprising that women typically believe they do not meet media expectations for beauty. They are bound for failure because they strive to achieve a standard of beauty that includes a slimness well below average. Media ideals create enormous pressure on women to pursue a thinner, more acceptable body. Some writers and theorists (McCarthy, 1990; Richins, 1991; Winkler & Vacc, 1989) have suggested that the presentation of women in the media as uniformly thin and beautiful has created dissatisfaction among the majority of women about their

appearance. So much dissatisfaction that it causes unhealthy attempts to meet the ideal, which can eventually lead to drastic measures such as eating disorders.

Acknowledging sociocultural influences. According to a sociocultural model, "eating disorders should primarily be attributed to society's obsessive preoccupation with food, thinness, and dieting" (Stolyen & Laberg, 1990, p.54). Striegel-Moore, Silberstein & Rodin (1986) suggest that women who deeply internalize this cultural standard of thinness as acceptable and beautiful are at the most risk of developing an eating disorder. In fact, a study done by these authors found that bulimic women expressed greater acceptance of this sociocultural value than did nonbulimics. Striegel-Moore et al. (1986) go on to suggest that certain environments, like boarding schools and colleges, and certain professions, like dancing and modelling, act as mediating factors in the internalization of this cultural value of thinness. Even more than the overall culture, these subcultures create immense pressure to conform to a body type that is unrealistic and unattainable for most people.

Conflicting media messages. Smith (1993) criticizes Striegel-Moore's discussion of media within her sociocultural model (1986) as unable to account for the conflicting media messages to both self-deny and consume. Stice (1994) notes that parallel with the thin ideal is an increase in the number of dieting and weight loss advertisements targeting women. Rodin, Silberstein, and Striegel-Moore (1985) suggest that the focus on dieting not only glamorizes the thin ideal but also actively promotes eating disorders. It seems then, that the message is a double edge sword when one considers that 70% of food commercials seen by children each year are for edibles that are "junk foods" (Smith, 1993). Smith (1993) further questions the ability of the sociocultural perspective to account for the increase of obesity in

the same population that is seeing an increase in eating disorders. He suggests that the media sends conflicting messages to women to both eat and starve (Smith, 1993). However, sociocultural factors of eating disorders, regardless if they fully account for all eating disorder syptomatology, certainly influence the development, maintenance and prevalence of them in our society.

Feminist Frameworks

The traditional medical model is only one way of understanding human problems and the social context. The medical model tends to look at individual pathology and sees the problem as solely intrapsychic in nature. The sociocultural model considers factors like the cult of thinness and internalized standards of beauty to be fundamental to the development and maintenance of eating disorders. A feminist model looks at the context surrounding eating disorders and seeks to understand the connection between the conditions of our lives and women's relationship with their bodies (Brown, 1993).

According to the feminist perspective, eating disorders need to be understood within a culture where 90% of women are dissatisfied with their bodies (National Eating Disorder Information Centre, 1991). The feminist conceptualization of eating disorders provides an alternative to other models which dichotomize "normal" and "abnormal" and offer instead, a view of eating disorders placed on a continuum (Brown & Jasper, 1993). Dieting and weight control have become the norm for women, an accepted way of life (Surrey, 1982). Anorexia and bulimia nervosa are extremes on a continuum that can include weight preoccupation, yo-yo dieting and body shame (Brown, 1993; Scarano & Kalodner-Martin, 1994). A continuum perspective provides a larger lens for viewing

eating disorders. It seems illogical to pathologize and stigmatize individuals at the extreme end of the continuum (people with anorexia and/or bulimia) at the same time as behaviors on the lower end of the continuum (dieting and exercise for weight control) are rewarded and praised. The similarities between people who struggle with anorexia and bulimia and those who struggle with dieting and exercise (Wooley & Lewis, 1989) allows us to question the traditional understanding of eating disorders. The societal value of thinness and the Western tendency to base much of a woman's value on appearance all bear tremendous significance for women's relationships with their bodies.

Women and their bodies. Certain tendencies in women's psychological development leave women particularly vulnerable to suffering in relation to the body. A female's relationship to her body is distorted by the fact that society teaches girls that their physical appearance is of the utmost importance. Essentially, girls are taught to be attractive not active, and thus parts of self are fragmented and excluded from their identity (Young, I., 1990). Culture gives girls and women ambivalent messages about the female body, namely that personal worth is measured exclusively by the appearance of the body and that the female body is shameful.

Current cultural definitions of females are dictated by a social system that controls and oppresses women by defining them primarily in terms of their bodies. The present western culture defines female as "other", as "object", and as "commodity" and this affects the relationship women have with their bodies (Hesse-Biber, 1996; Young, I., 1990). As Nancy Chodorow (1989) states, "The flight from womanhood is not a flight

from uncertainty about feminine identity but from knowledge about it." (p. 43). A woman learns from the culture that her body is her life's work.

Eating disorders and the body. Eating disorders seem to be connected to the level of comfort (discomfort) people have with their bodies (Young, 1992). Lester (1995) suggests that the boundaries of the body may symbolize the boundaries of the self. She suggests food is a substance that crosses the boundaries of "me" and "not me" and therefore can be used to restructure the boundaries of self in response to culturally constructed concerns about autonomy. The body certainly holds an important piece of the "self" puzzle and perhaps for women with eating disorders the body is both everything and nothing. Cross (1993) notes that women are paradoxically both alienated from and attuned to their bodies at the same time. The evaluation of self for eating disordered individuals may be largely or solely based upon their perception of their bodies (Hesse-Biber, 1996; Pipher, 1995; Vitousek & Hollon, 1990). At the same time, individuals with eating disorders are never satisfied with their bodies and usually are out of touch with physical sensations such as hunger (Garner & Garfinkel, 1985). The body becomes alienated and fragmented in an attempt to own the body and define the self. As Berger (1972) states, "Women watch themselves being looked at....thus turn [themselves] into an object....[The woman] comes to consider the surveyor and the surveyed within her as the two constituent yet always distinct elements of her identity as a woman." (p. 46-47). The female body is an available arena for the expression of the confusion of female identity and the "self as body" may be the only conceptualization of self available to sufferers of eating disorders (Mahoney, 1990).

More than appearance. Conceptualizing eating disorders as a manifestation of the discovering of self, takes away the guilt and shame of a disorder that been attributed to an attempt to reach an unobtainable beauty ideal. Research suggests that eating problems start as strategies to solving problems (Thompson, 1992). The idea of eating disorders as coping mechanisms (Brown & Jasper, 1993) is a feminist idea that does not discount the societal pressures or the discrepancy between the reality of women's lives and the representation of them. Eating disorders are about more than food and appearance; they can be conceptualized as a search for self.

Relational Models

The relational models of self-development (Enns, 1991) add much needed information to the development of the self for women. Gilligan's (1982) "different voice" adds the notion that one can take care of self while in relation to others (Enns, 1991). For the eating disordered individual, this may mean defining self outside the role of the body and the "failed" attempt to be completely autonomous. Thus, one of the challenges for all women is to develop a unique sense of self while still valuing their relationships (Steiner-Adair, 1986). The current cultural value of autonomy outside of relationships makes it difficult for women to integrate their interest in relationships with their sense of self. Surrey's self-in-relation model can be helpful in this regard. She (1991b) proposes that differentiation be redefined as the process of change and growth of each individual in a connected, healthy and equal relationship. She suggests that it is not through an increase in separateness or autonomy, but rather through relational experience that the development of a distinct self takes place. However, it is easy to see how relational needs

of women could be seen as dependency or lack of autonomy in the current cultural preference for independence (Kaplan, Gleason, & Klein, 1991). Surrey (1991a) suggests that the larger context of the devaluing of relationships is strongly related to the disturbances women face in relation to food, eating and the body. The devaluing of connectedness and the denial of the strength it takes to care in our culture, leaves women's need for a relational sense of self alienated and degraded (Steiner-Adair, 1986).

Implications for treatment. If the body is viewed as a metaphor for the drawing of self boundaries, or essentially as an indication of the emerging self, then care must be taken in the treatment of individuals with eating disorders. The self may be lost in the connection the woman has made with the eating disorder because the eating disorder provides an identity, and perhaps the only sense of self (de Groot, 1994). The emergence of the "real self" needs to take place in the context of a safe, healthy and connected therapeutic relationship (Romney, 1995). "To be well bounded is to know the difference between inside and out, be it food, people, ideas, or values around slimness." (Romney, 1995, p.59). Further for the individual struggling with the eating disorder, the problem needs to be externalized and differentiated from the self. Hooks (1990) stresses the importance of "...becoming your own person..." (p. 219) by moving from being an "object" to being a "subject" of your own experience.

Women are already alienated from their bodies because of culture's negative valuation of the female body. Women with eating disorders experience their bodies as even more separate from self or as a totally alien object (Young, 1992). Eating disorders may force women to deal with their own embodiment in different and better ways.

Treatment needs to focus on the bodily experiences of women that are culturally devalued and provide an avenue to explore subjective embodiment.

Practical application to eating disorders. Although the theories of connectedness have added much needed information about the development of women's sense of self, caution must be taken not to glorify connectedness (Romney, 1995). Individuals with eating disorders need to develop a sense of self that allows for the expression of both autonomy and connectedness. The therapist must not be drawn into the pattern of either/or thinking, and must remain available to encourage the entire continuum of experiences between autonomy and connectedness. These constructs must not be polarized as male-female opposites, but rather seen as variables that can exist simultaneously in any self's experience (Enns, 1991). Further, the therapist must allow for expression of self not defined only in terms of the body and must encourage expressions of self-defined outside of cultural expectations. Perhaps the relationship models of self can facilitate the development of a more positive relationship between women and their bodies. By responding to one another as embodied subjects, reparation of the aspects of self that were never nurtured can begin.

Summary. By connecting how women fit into an historical and cultural picture the meaning behind the continuum of eating disorders becomes clear. When the entire continuum of weight preoccupation is placed within the current social context, the similarities between the development of an eating disorder and most women's preoccupation with thinness becomes apparent. With the numerous ways that eating disorders are conceptualized, it is not surprising that consensus has not been reached

about the most effective form of treatment. Treatment practices have transformed and developed in accordance with the new theories and models.

Treatment Modalities for Eating Disorders

As the conceptualization of eating disorders has changed, so have the treatment practices. There is a rich literature on the use of cognitive and behavioral approaches with some treatment issues of eating disorders such as negative body image and cognitive distortions (Kearney-Cooke & Striegel- Moore, 1994). In fact, cognitive and behavioral approaches have been well documented as effective forms of treatment for anorexia nervosa and bulimia nervosa (Cooper & Steere, 1995; Young, F., 1990). It is important to note, however, that most studies on cognitive-behavioral treatments are limited by various methodological problems (Stoylen & Laberg, 1990). Also, some studies show that non-behavioral approaches are as effective and that cognitive-behavioral treatment is equally effective in individual and group settings (Stoylen & Laberg, 1990).

The potential for cognitive-behavioral therapies to be unnecessarily controlling came to fruition in the 1970's when women with eating disorders were coercively hospitalized and put on behavioral programs that included intravenous or tube feeding systems (Brown, 1993). Much of the treatment tended to focus on behavioral techniques around food and weight. Traditional descriptions of "anorexic or bulimic behavior" deem the behaviors bizarre and irrational and the treatment echoed this sentiment. Women were supervised in the bathroom and treatment was complete when the staff concluded that enough weight had been gained. The compliance and passivity necessary to be

"successful" in these programs did not lead to continued success outside these institutions (Brown, 1993).

Feminists in the early 1980's began to see how taking the control away from women and their bodies only exacerbated the problem. Srebnik & Salzberg (1994) combined feminist principles and cognitive-behavioral therapy to treat negative body image. The feminist cognitive aspects include normalizing and relabeling beliefs with the continuum in mind and developing counter-arguments and adaptive statements given the cultural context in which we live. The feminist behavioral aspects include kinesthetic experiences and nurturing behaviors.

The evolution of models and treatment modalities has lead to a proliferation of group treatments for eating disorders. As feminist principles and ideas, like the relational model, become more accepted, treatment begins to reflect and illuminate the psychology of women.

Group Therapy for Eating Disorders

Given the importance for women of developing in relation to others, it is not surprising that a variety of group therapy modalities have been used to treat eating disorders. A number of researchers suggest that group psychotherapy, regardless of the paradigm or modality used, is the treatment of choice for people with anorexia and bulimia (Edmands, 1986; Kettlewell, Mizes, & Wasylyshyn, 1992; Kuba & Hanchey, 1991; Lenihan & Sanders, 1984; Thorton & DeBlassie, 1989). Unfortunately, many studies comparing the relative effectiveness of different types of therapy for eating disorders are not adequately controlled (Kettlewell et al., 1992; McKisack & Waller,

1996). Concurrently, both open and controlled studies demonstrate that group therapy is effective, regardless of the therapeutic orientation of the group (McKisack & Waller, 1997). However, caution must be exercised about any conclusions regarding which therapeutic variables in the group process result in significant positive change because most studies are inconclusive.

Use of Reflecting Teams

Recent interest in a certain type of group, reflecting teams, has influenced the work of many therapists. The use of reflecting teams is based on the premise that the group or system is stuck in sameness and the reflecting team offers different points of view that group members might take into consideration (Anderson, 1987). The process of reflecting entails a team composed of professionals watching the group therapy session through a one way mirror. The team then reflects to the group and the therapist(s) what they have observed while the therapy group listens. Team members bring their own perspective, just as each group member may be in a different place of recovery. Thus, the group can take what they want from the reflecting team discussion and leave the rest.

Qualitative studies have substantiated the helpfulness to clients of the reflecting team's multiple perspectives (Smith, Winton, & Yoshioka, 1992; Smith, Yoshioka, & Winton, 1993). Therapists on reflecting teams have suggested that the approach is positive as long as multiple perspectives do not bring about chaotic discussion. Recommendations include an emphasis on positive, supportive, and brief statements from the reflecting team members and a discouragement of negative, long-winded statements thought to be less constructive (Moran et al., 1995; Sprenkle & Bischof, 1994).

Reflecting teams are useful in demonstrating how ideas change through discussion and negotiation. Further, they demonstrate that the client knows what is most useful for them (Biever & Gardner, 1995). The reflecting team process creates a context where the concept of expert is de-emphasized and the possibilities and boundaries are expanded for both the clients and the therapist (Gorman, Lockerman, & Giffels, 1995; Prest, Darden, & Keller, 1990).

The use of a one-way mirror in the reflecting process may hold symbolic meaning. Often individuals struggling with eating disorders have a poor sense of self or even a sense of selflessness (Brenner & Cunningham, 1992; Hsu, 1990; Ryle & Evans, 1991). This self-hatred can manifest with difficulty looking in a mirror or, at minimum, disgust for what is seen in the mirror. The one-way mirror of the reflecting team offers a different interpretation, a new way of seeing oneself because the team offers diverse perspectives once removed from that one way mirror. The reflecting team approach appears to be a viable addition to the group process for individuals struggling with eating disorders.

An Examination of Group Therapy for Eating Disorders

While reflecting teams have been used for family therapy and for counselors in training (Anderson, 1987), their use has not previously been documented with an eating disorder psychotherapy group. There are a number of ways in which the reflecting team has potential to highlight the group interaction and potentially be an additive component to some of the benefits of group therapy. From a review of the literature, six themes can be identified as characteristic of people struggling with eating disorders. The six themes reviewed in this section include isolation, healthy relationships, dichotomous thinking,

control, perfectionism, and emotional expression. First, the themes described in the literature will be reviewed, followed by a description about the proposed ways that the reflecting team can be additive to the group process.

Isolation

Theoretically, group therapy appears to offer numerous opportunities for recovery from eating disorders. Some common themes in eating disorder literature include isolation, secrecy, and a fear that one's story is unique and unusual and that no one understands (McKisack & Waller, 1996). The literature suggests most often that group therapy may be particularly useful for combating the isolation of people struggling from eating disorders (Hsu, 1990; Thorton & DeBlassie, 1989). The social context of group therapy offers a unique opportunity to break the secrecy and combat the isolation simply through attending and participating.

Group therapy has been thought to be the treatment of choice for people with eating disorders because it combats the isolation and shame surrounding these disorders (Laube, 1990; Thorton & DeBlassie, 1989; Zimmerman & Shepherd, 1993). The secretive nature of eating disorders is broken in a group setting because group psychotherapy is a social interaction (Lichtenberg & Knox, 1991). The reflecting team may help combat this isolation more effectively as the secret is shared with more that just the group members. Perhaps the reflecting team helps the generalizability of the process that challenges shame and isolation above and beyond the format of group therapy because it provides an additional and alternative avenue for interaction.

Healthy Relationships

Perhaps as a result of this isolation, people with eating disorders struggle with developing healthy intimate relationships (Zraly & Swift, 1990). Group therapy can provide a collaborative environment where people can express themselves without judgment. Further, the group context has the potential to offer opportunities for altruism and practicing social skills such as giving and receiving peer reinforcement and feedback. The development of this skill set is noted as important for the development of trusting relationships (Dixon, 1988). Additively, feminist research suggests that it is particularly important for women to develop a sense of self in relation to others (Surrey, 1982). Group therapy offers a context for developing trust and empathy for others at the same time as these feelings are developed for the self (Kuba & Hanchey, 1991).

The group and the reflecting team offers further opportunities to deal with the anxiety and ambivalence people with eating disorders feel about the fear of close, healthy relationships at the same time as they feel a strong desire for them. For example, during the reflecting process itself, the group and the team are together and the team communicates its ideas in the open (Andersen, 1992). This process models open communication and sharing of ideas important in establishing and maintaining healthy relationships.

Dichotomous Thinking

Another core symptom of people with eating disorders is black and white or dichotomous thinking (Garner & Garfinkel, 1985; White, 1983). Involvement in a group allows for the possibility of being introduced to alternatives never considered in the narrow focus of personal perspectives. This sharing of ideas allows a different or

alternative response to the same dynamic therefore planting the seed for the creation of new meaning (Barth, 1994). This also opens the door to enhance problem solving ability by learning to generate alternatives and see a variety of possibilities.

The reflecting team offers alternatives and speculations about this dichotomous thinking while emphasizing the speculative nature of their perspective (Andersen, 1987; Andersen, 1991a). There is a significant shift from an either-or perspective to a both-and stance which has the potential to be freeing (Andersen, 1992). Discussion among team members may create previously unheard ideas increasing the number of alternatives available to the group (Sells, Smith, Coe, Yoshioka, & Robbins, 1994).

Control

Control also seems to play an important role in the symptomology of eating disorders (Brown & Jasper, 1993; Zraly & Swift, 1990). People struggling with eating disorders tend to feel a need for control at the same time as they feel helplessly out of control (Baumann, 1992). The group experience can offer opportunity to challenge this need to be in control as a certain amount of risk taking is involved in simply participating. The group context , more so than individual counseling, is perhaps a more difficult environment for the client to feel in control. In one-on-one counseling, there are only two people to consider where as in the group setting, participation includes a large number of people and this can become unpredictable.

The process of the reflecting team discussing their observations without room for the group members to interrupt or respond directly (essentially have no control) opens the door to an opportunity to process the issue of control. At the same time it offers an

opportunity for the group to exercise choice and control because they are invited to take what they want from the reflections and leave the rest (Andersen, 1991b).

Perfectionism

Perfectionism has been noted in the literature as a common characteristic of individuals with eating disorders (Thurstin, 1992). Often people struggling with eating disorders feel a need to be successful and flawless at whatever they endeavor. Failure is not an option so trying something new becomes risky because of a fear that perfection will not be reached. Similar to dichotomous thinking, the group atmosphere allows for a diversity of opinions and definitions around perfection. The group experience provides an opportunity for both successes and learning experiences to be shared, therefore breaking the appearance of perfection that many people with eating disorders strive to reach.

The reflecting team, by modeling respect for the diversity of ideas and focusing on the process not the result, model important behavior for the group members (Friedman, 1995). Further, the reflecting team's dialogue is unrehearsed (Sells et al., 1994) leaving room open for the humanness of the reflecting team to create equality and model human imperfection. Because each team member brings their own perspective or version of the issues that have been discussed, a certain amount of uncertainty in phrasing and openness to diversity is required (Andersen, 1991b).

Emotional Expression

Women with eating disorders often mask their emotional expression, especially in front of others (Kuba & Hanchey, 1991). This is not surprising since in our culture food and eating are filled with meanings. In fact, the majority of women in our culture eat for

emotional reasons (Zimberg, 1993). However, much like with eating disorders, emotional eating is about much more than just food (Brown & Jasper, 1993). More often than not it is about feelings, and eating is a vehicle for their indirect expression. For example, people with anorexia often describe themselves as void of feelings (Kuba & Hanchey, 1991) while people with bulimia describe using food as a way to avoid emotions (Brouwers, 1994). Group therapy has the potential to establish norms of honest and direct expression of emotion and feelings in a safe and nurturing environment.

The difficulty that people struggling with eating disorders often face when confronted with strong emotions can be processed in a safe environment. The reflecting team can address safety issues and model ways to express emotions during their reflections. Modeling that emotions are neither good nor bad but just exist, helps to create the possibility that emotions are manageable.

Summary

Reflecting teams have not been evaluated for their contribution to group therapy for eating disorders. Theoretically, it seems that reflecting teams might be an additive component to group therapy, however, this has never been studied. Thus, one of the purposes of this study is to test the potential themes emerging from the group therapy interaction for their usefulness in the recovery of women with eating disorders.

Conclusion

Based upon the literature on eating disorders and upon the new and increasing use of reflecting teams as a therapy modality, the present study attempts to understand themes related to recovery by examining the voices of the women who suffer. It is hoped that this

study will uncover important themes related to recovery and treatment. Each woman in this psychotherapy group is at a different place on the continuum of eating disorders, and it is hoped that by studying the similarities and differences in their experience, the process of rediscovering self can be uncovered. The qualitative methodology planned for this study is sensitive to the lived and changing experiences of women in order to understand how women regain their sense of self. Uncovering themes and ideas produced directly by this group of women with an eye to the extensive literature base on eating disorders and the emerging literature on reflecting teams, has potential to lead to a better understanding of issues that are important to recovery. An exploration of the therapeutic variables in the group interaction has the potential to advance our understanding of the treatment of eating disorders. In the next chapter, the research methodology will be outlined and illuminate how this study was designed to be sensitive to the lived and changing experiences of women.

CHAPTER 3: METHODOLOGY

Method

Chapter Two outlined the basic research questions concerning group therapy for women with eating disorders. In Chapter Three, an explanation of the research method used to explore these issues is outlined. First, the purpose of the study is reiterated. Then, a brief introduction to grounded theory as a methodology is presented, followed by an explanation of how grounded theory and feminist principles will be integrated into this study. Fourthly, specific procedures involved with grounded theory methodology will be outlined with a focus on the application to the specific procedures used for this study. Finally, an evaluation of the trustworthiness of this study will be discussed.

Purpose of Current Study

The purpose of this study is to uncover themes and ideas from the interaction in group therapy for women struggling with eating disorders. Of particular interest is the influence of reflecting teams on group therapy. Uncovering themes and ideas produced directly by this group of women has potential to lead to a better understanding of issues that are important to recovery. Therefore, a research method that would allow women's own voices to be heard was chosen to investigate these matters. Grounded theory supported by feminist principles was the method of data analysis used in this study.

Some qualitative theorists argue that one should not engage in an extensive literature review prior to collecting data (Strauss & Corbin, 1990). However, others such as Glesne and Peshkin (1992), believe that "knowledge of the literature will help you to judge whether research plans go beyond existing findings and...contribute to the field of

study" (p. 17). Given the vast amount of research on eating disorders and the researcher's prior experience in the literature, an extensive review seemed appropriate for two reasons. First, the literature review helped determine this study's potential to fill some of the gaps in the literature around the therapeutic variables involved in group therapy for eating disorders. Second, it facilitated declaring any biases or influences the researcher had prior to looking at the data. An attempt was made to put aside or "bracket" biases and expectations (Rennie, 1994) through the process of reviewing the literature and making the implicit, explicit. By making suggestions in Chapter Two about how the group process has potential to contribute positively to people struggling with eating disorders, my biases and expectations were clearly stated and examined. An "explicit acknowledgement of assumptions helps to contain their influence" (Rennie, Phillips, & Quartaro, 1988, p. 141). The assumptions and knowledge of the researcher are particularly important in the grounded theory method, which is outlined next.

Overview of Grounded Theory

Grounded theory as a qualitative methodology came to the forefront with the publication *The Discovery of Grounded Theory: Strategies for Qualitative Research* by Glaser and Strauss (1967). This constant comparison approach to data analysis was developed as an alternative to popular quantitative approaches that sought to verify rather than generate theory (Glaser & Strauss, 1967; Martin & Turner, 1986). Grounded theory is particularly appropriate for this study as much of the previous literature on eating disorders has been informed by mostly quantitative methodological approaches. These quantitative methods have allowed the conclusion that group therapy for eating disorders

is effective. This study is directed at uncovering *how* group therapy may be helpful through the development of a theory.

The purpose of grounded theory is to uncover and produce a theory directly from the data.

> Grounded theory is a general methodology for developing theory that is grounded in data systematically gathered and analyzed. Theory evolves during actual research, and it does this through continuous interplay between analysis and data collection. A central feature of this analytic approach is 'a general method of [constant] comparative analysis' (Glaser & Strauss, 1967, p.vii); hence the approach is often referred to as the constant comparative method (Strauss & Corbin, 1994, p.273).

The major emphasis in grounded theory that separates this methodology from others is the emphasis on theory development (Strauss & Corbin, 1994). Theory is generated in the course of research through close, systematic inspection of the data (Henwood & Pidgeon, 1992). Further, grounded theory is more than a description of data; it is an interpretation that is constructed and informed by the data collected (Clegg, Standen, & Jones, 1996). The purpose of the interpretation is to represent and make meaning of human experience and behavior (Rennie, 1994).

Because grounded theory is a model of theory building, it is based upon theoretical assumptions. Overall, grounded theorists adhere to the notion that reality is a social construct that is always changing (Rafuls & Moon, 1996). Hutchinson (1993) claims that grounded theorists share three common core assumptions. First, grounded

theorists assume that even though people's realities may seem chaotic to an outside observer, people actively make sense of their environment and reality. Secondly, people in similar environments create shared meanings and therefore a shared reality. Thirdly, grounded researchers assume that such groups share a "specific social psychological problem that is not necessarily articulated" in their reality (Hutchinson, 1993, p.185). This study examines women sharing a common reality of suffering from an eating disorder in group therapy.

Grounded Theory and Feminism

Grounded theory and feminism share some common principles. Grounded theory allowed room for many of the feminist principles that the researcher adheres to in practice. There seems to be some degree of fit between the researcher's feminist perspective and the underlying principles of grounded theory (Wuest, 1995).

It was important to the researcher that the theory uncovered through the research remained true to the experiences and voices of the women that have struggled with an eating disorder. The notion that reality is socially constructed is an underlying principle of both grounded theory and feminism (Hutchinson, 1993; Wuest, 1995). Both ideologies take this further to adhere to the idea that there are multiple realities and truths, not just one real and all-powerful reality (Myers-Avis & Turner, 1996; Rafuls & Moon, 1996). A feminist perspective is a lens that adequately allows this group experience to be both unique and common in some way to all women (Brown & Jasper, 1993). Likewise, grounded theorists are motivated by the knowledge that all concepts and ideas about any particular phenomenon have not been fully explored (Strauss & Corbin, 1990).

Grounded theory became the methodology of choice also because it assumes the researcher to take responsibility for the interpretation of results (Strauss & Corbin, 1994). Because the researcher in this study has personal experience in overcoming an eating disorder, grounded theory provides an avenue to utilize this experience in the interpretation of the women's voices. Quantitative methodologies may consider this a liability because of the potential difficulty separating objective and subjective facts, but grounded theorists accept the value-ladenness of facts (Rafuls & Moon, 1996). Grounded theorists describe theory as a product of an interaction between the researcher and the phenomenon under study (Turner, 1981). Likewise, most feminists agree that science does not represent reality, rather, researchers create realities (Myers-Avis & Turner, 1996). Attaining the knowledge directly from women who have experienced the struggle (in this case, both the researcher and the participants) may better illuminate how as practitioners we can best empower our clients.

It is important that the results be useful not only to practitioners who work with women but also to the women who themselves struggle with eating disorders. Grounded theory suggests that because the theory is developed so closely to the data that it is likely to be useful to those who participated in the study (Turner, 1981). One of the most important feminist research principles is that the "knowledge produced by the research should be useful for the participants" (Harding, 1987; Wuest, 1995, p. 129).

Another important assumption of feminist philosophy that needed to be matched to a methodology is consideration of the sociocultural context of the women in the group. There is a certain culture that is developed when these women are together but the

influences of the larger sociocultural context are also important. For example, the theory that is uncovered must be placed within a context where 90% of women are dissatisfied with their bodies and dieting is the norm (Brown & Jasper, 1993). Similarly, Corbin and Strauss (1990) suggest that broader social and structural conditions must be analyzed and integrated into the theory. The focus on contextual influences is consistent with both feminist thought and grounded theory methodology. Wuest (1995) concludes that, "grounded theory is a method of knowledge discovery that can be conducted from a feminist perspective" (p.135).

Grounded Theory Methodology

Grounded theory is a general way of thinking about data and research (Strauss & Corbin, 1994). Essentially the procedures outlined for grounded theory researchers focus on discovering patterns and process (Strauss & Corbin, 1994). Grounded theory has specific guidelines about the procedures to be followed including, theoretical sensitivity and sampling, data collection, and data analysis. The purpose of this section of Chapter 3 is to describe how grounded theory has been applied to this particular study. The application begins with a description of theoretical sensitivity and sampling procedures, followed by procedures for data collection and analysis. Finally, evaluation criteria for the study will be outlined including credibility, transferability, dependability, and confirmability.

Theoretical Sensitivity

Theoretical sensitivity is often associated with grounded theory (Glaser & Strauss, 1967). Theoretical sensitivity is a personal quality in a researcher and can be developed

through literature reviews, analytic experience with data, and professional and personal experience. Several measures were employed throughout this study to maintain theoretical sensitivity.

Literature as a source for theoretical sensitivity. Grounded theorists recommend reviewing enough of the literature to sensitize to the research and have a general understanding of the phenomenon being studied (Strauss & Corbin, 1990). Strauss and Corbin (1990) caution that too thorough an understanding of the literature may unduly influence the researcher and constrain creativity. Concurrently, not enough prior reading has potential to leave the researcher uncertain and desensitized to general ideas because of a lack of understanding. In this study, pre-existing notions and ideas were outlined clearly in Chapter Two of this study in order to lessen their influence.

Analytic experience with the data. As the researcher becomes more involved in looking at and experiencing the data, theoretical sensitivity increases. Interaction with the data helps the researcher become more in tune with the phenomenon and generate and connect insights. Grounded theory is generative and the more interaction the researcher has with the data, the more ideas, insights, and questions are produced.

Professional and personal experience. Again, although personal and professional experiences enhance theoretical sensitivity, they also have potential to hinder creativity. Professional experience in an area may help the researcher to more quickly identify relevant ideas but may also hinder the researcher in seeing more obvious themes (Strauss & Corbin, 1990). Similarly, personal experience can enhance sensitivity as long as the

researcher is open to other's experiences being different and unique from their own (Strauss & Corbin, 1990).

Of particular importance in this study is my own professional and personal experience with eating disorders. From my experience both personally and professionally, I have concluded that eating disorders (at least as defined on the feminist continuum) are outrageously common. Secondly, my academic experience has taught me that the most useful conceptualization of eating disorders is the feminist continuum because it considers women with eating disorders in context. Thirdly, therapeutic experience as well as my personal struggle with eating disorders, has helped me relate to and understand the strength and resiliency required to overcome the influence of an eating disorder. Although my personal experience does have the potential to dull my openness to more obvious ideas, I believe it is an asset in this study because the voice of interpretation is also a voice that has experienced an eating disorder. Further, after over 6 years of recovery and some professional experience in this area, I am fully aware that eating disorders manifest themselves differently in every person. My passion for this area of study has a history in my own struggle with eating disorders. However, it is a history expanded by professional and academic knowledge and a belief that women can overcome the challenges faced in their journey toward their sense of self.

Theoretical Sampling

Because the basis of analysis in grounded theory is concepts, choosing which concepts to study becomes a matter of importance. Concepts are considered relevant when they are repeatedly present or notably absent when comparing events (Strauss &

Corbin, 1990, p. 176). Research initially involves open sampling: uncovering all new concepts and categories that may have relevance to the topic (Strauss & Corbin, 1990). The purpose of sampling is to sample the incidents that are relevant to a concept or category to gain insight into how they relate.

Further, part of sampling includes the decision about which groups, individuals, and environments are chosen as points of interest for the phenomenon being studied (Corbin & Strauss, 1990). Open sampling can take on a number of different forms: 1) *Purposeful sampling* where settings are deliberately chosen because of their relevance to the area of interest being studied. 2) *Systematic sampling* involves a predetermined strategy for finding participants. 3) *"Accidental" sampling* occurs when during the course of research one recognizes the importance of an event or is referred to a participant by other people.

Initially, the researcher is interested in what is central to the phenomenon studied and therefore, is likely to select participants who represent the phenomenon and who are similar (Rennie et al., 1988). Participants for this study were chosen based on their ability to provide rich accounts of the phenomenon being studied (Glaser & Strauss, 1967). Based on the knowledge a researcher brings about a specific phenomenon, the site for research is chosen. This study deviated from traditional sampling procedures for grounded theory because participants were chosen and confirmed a priori. Specifically, this study employed purposeful sampling because the researcher was unsure as to which theoretical concepts were relevant. Ideally, grounded theory states that ongoing sampling takes place and data collection and analysis occurs simultaneously. However, grounded

theory also allows room for flexibility and modification of their procedures (Strauss & Corbin, 1990). Because of the vast amount of data produced by the psychotherapy group, other forms of sampling were not employed in this study. Further, because the researcher was also co-facilitator of the group, the data collected was not analyzed until the completion of the group. This is anti-theoretical to grounded theory procedures but this clear division of roles allows the interactions of group therapy to be uncovered with less influence from the present researcher. Thus, this grounded theory uncovered from this data will need to be elaborated and modified by future studies through theoretical sampling.

There are three overriding areas of inquiry related to this study. First, this study attempts to explore the participants' perspectives to understand what women with eating disorders themselves think is important to the recovery process in group therapy. Secondly, this study explores how the use of a reflecting team contributes to group therapy. Finally, group therapy is thought to be effective for people with eating disorders and this study attempts to uncover how it is useful.

Sample selection. Participants were voluntary adult members of an eating disorder psychotherapy group at The Calgary Counseling Centre (formerly The Pastoral Institute) and members of the reflection team (see Appendix A & B for letter of invitation and consent information). All participants followed the general procedures mandated by the agency. Potential clients contact the agency and are assigned to a primary therapist for the initial phase of treatment where assessment takes place and individual counseling may be received. The Calgary Counseling Center's policy requires this phase to discuss

possible treatment plans, which may or may not include the psychotherapy group. If clients choose the psychotherapy group as part of their treatment plan, a medical exam and a statement of medical stability is required from a physician before participation and the client must agree to work closely with their medical physician for the duration of the group sessions. Concerns regarding physical safety of the participants were managed by the Calgary Counseling Centre and the medical exam was in no way used in the present study.

Group participants were clients interested in joining a 2-hour per week, 14-week group for eating disorders. Clients indicated some evidence of purging and restricting behaviors, however, there was no formal screening process and clients did not have to fit DSM-IV (APA, 1994) criteria for anorexia nervosa or bulimia nervosa. Compulsive eaters were not included since the Calgary Counseling Centre offers a separate therapy group for them. Participation in the psychotherapy group was strictly voluntary and all clients were over the age of 18. Participants ranged in age from 18 to 37, incomes indicated middle class socioeconomic status and all participants were White women. The duration of the eating disorder was not available at intake but participants were assessed as ready for group treatment. The attrition rate was expected (McKisack & Waller, 1996) but notable. Session one began with 9 participants. After sessions one, four, and seven one member dropped out of the psychotherapy group.

The Calgary Counseling Center requires a signed letter of agreement from participants regarding medical examinations, medical stability (see Appendix C), a letter of consent for research regarding effectiveness of the agency's program (see Appendix

D), and a letter of consent for permission to videotape the sessions (see Appendix E). For participants who do not want to participate in research, individual counseling was an immediate option and a non-research group would be offered by the Calgary Counseling Center at the earliest possible time.

Other participants included members of the reflecting team. The team was composed of staff and volunteers from the Calgary Counseling Centre, volunteer therapists and volunteer community members screened and supervised by the agency. See appendix F & G for a letters of approval and support for my research project from the Calgary Counseling Center.

Data Collection

The type of data used in grounded theory can vary from historical documents to formal interviews. When the researcher is focused on examining people sharing a common experience, an effective research tool is some form of structure (Kvale, 1996). A certain amount of structure is needed in order for the group therapy to function, however, by not being too directive, the interviews are lead by the participants in the group. This format allows individuals to speak about what is relevant and important to them concerning their experience with the phenomenon. This is fundamental to qualitative research as the phenomenon under study should unfold as the participant sees it, not only as the researcher views it (Marshall & Rossman, 1995). Feminist researchers also adhere to the idea that the purpose of research is to develop knowledge that is representative of women's voices (Wuest, 1995). Through establishing a warm and trusting relationship, the result is the co-construction of richer and more complete information through

collaboration (Wuest, 1995). With group therapy and eating disorders this is particularly important because most studies tend not to focus on the voices of the group participants (Klemchuk et al., 1990 ; Levitt, 1992).

For this study, data were collected through transcribing the 14 videotaped group therapy sessions where reflection teams are incorporated into the group structure. In total over 28 hours of group therapy were collected and analyzed through 14 weeks of interactive group therapy. The transcripts did not contain any identifying information. All group therapy sessions, which averaged 120 minutes, were conducted at the Calgary Counseling Centre.

The first session began with an explanation of fees and administrative tasks required for the Calgary Counseling Centre. Then the present researcher explained the study, distributed the consent forms and answered any questions. All participants, including the reflecting team members agreed to participate in the study. Each group therapy session was videotaped. After each session, the videotape was labeled and stored in a locked room at the Calgary Counseling Centre.

After completion of the group, the videotapes were transferred to audiotape through collaboration with the Calgary Counseling Centre. The videotapes, once transferred, were stored in the locked file room at the Calgary Counseling Centre and the resulting audiotapes contained no identifying information on the outside. The audiotapes were stored in a locked cabinet at the researcher's home.

Data transcription. All audiotapes were transcribed verbatim by a professional using Windows '97. An electronic transcriber for cassettes was used to speed up the

transcription process. All transcripts were reviewed by the researcher for accuracy using the audiotapes and individual voices were identified (not actual names) for the purpose of analysis.

Group process. When a group is the focus of study rather than the individual, the focus is on individuals and their relationships with each other. The group must be a structured system in one way because it has definitions that separate or distinguish it as a group from the rest of the world (Manson, 1993). In the study, the "system" of group therapy is as important as "the parts" or the individuals in the group (Manson, 1993). Thus, the facilitator creates a safe environment, and asks questions to encourage discussion and the expression of opinions and feelings (Marshall & Rossman, 1995).

The group therapy format was unchanged for the purpose of the study. The present researcher was also co-facilitator of the psychotherapy group. The group was semi-structured and essentially the facilitators attempt to have the group themes emerge from the interaction between participants. This type of group was chosen as the primary research tool for this study because it suits the goal of understanding the women's experience in group therapy. A group format that imposed more structure and direction may have further restricted the voices of the participants.

Throughout the group therapy process the facilitators' tasks included clarifying, paraphrasing, reflecting, questioning, summarizing, and appropriate self-disclosure. The facilitators tried to keep the conversation "on track" in terms of the group discussing topics related to their experience with an eating disorder. Empathic listening was utilized in order to encourage dialogue and clarify ideas presented by participants.

Participant–observation. To some extent participant observation is essential to most qualitative research designs (Marshall & Rossman, 1995). First hand involvement in the phenomenon being studied allows the researcher to not only observe the social world but to experience it. This study required the researcher to be a fully functioning participant (sometimes referred to as participant-moderator in focus groups) in group therapy. This required the researcher to play two, sometimes conflicting, roles. In order to clearly set up boundaries about facilitation versus research, data analysis did not begin until after data collection was complete, meaning after the 14 weeks of psychotherapy group were done.

During the data collection, the researcher kept a journal in which she noted important observations. These observations included personal thoughts and experiences and any potential themes or theories. This type of memo (audit trail) helped to ensure the process remain true to the experiences of the people in group therapy. Patton (1990) notes, "A phenomenological perspective can mean either or both (1) a focus on what people experience and how they interpret the world or (2) a methodological mandate to actually experience the phenomenon being investigated." (p.70). It is through careful documentation of the development of group, the researcher became aware of biases, prejudices, and influences and was better able to account for the choices and decisions made during the group experience (Dey, 1993). The audit trail during the group enabled the present research to reach both goals of focusing on the group's experience while actually experiencing the phenomenon investigated. A similar audit trail was utilized during the data analysis.

Data Analysis

Past research with eating disorders has focused mostly on standardized test scores to determine the usefulness of treatment (Klemchuk et al., 1990; Levitt, 1992). This approach ignores the importance of the group interaction and the potential to uncover important themes related to recovery and treatment. Thus, it is fundamental that the methodology be sensitive to the lived and changing experiences of women to understand how women regain their sense of self in recovery. This research attempts to examine the unique and common experiences of women with eating disorders in group therapy by focusing on the interactions in the group.

The constant comparison method is at the center of analysis in the grounded theory method (Glaser & Strauss, 1967). This requires a process of direct interaction between the researcher and the data (Corbin, 1986). The data is continuously examined for similarities and differences between ideas, themes or categories. The researcher is always challenging concepts with fresh data, thus guarding against bias (Corbin & Strauss, 1990). Glaser and Strauss (1967) described the constant comparison method in four stages which include 1) comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting (reducing) the theory and 4) writing the theory.

The constant comparison method is achieved through coding. The quality of the research depends largely on the quality of coding (Rafuls & Moon, 1996) because theories cannot be built on raw data (Corbin & Strauss, 1990). "Coding represents the operations by which data are broken down, conceptualized, and put back together in new

ways" (Strauss & Corbin, 1990, p.57). There are three different types of coding that take place in the procedures of uncovering a grounded theory: open coding, axial coding, and selective coding. There are two procedures fundamental to all three coding processes: the making of comparisons and the asking of questions (Strauss & Corbin, 1990). Both these procedures help give the concepts uncovered in the coding process accuracy and precision.

In this study, the constant comparison method (Mason, 1993) was used to code the transcripts. This process involved the study of each new response to determine similarities and differences (Dey, 1993). If a response did not fit into previously identified themes, a new theme was created and all previous responses reviewed to determine if the new theme better encompassed the response. No limit was set for the number of possible emerging themes or the number of responses per theme. To remain true to the experiences of the women studied, emic categories were developed (Patton, 1990), however, classification of themes included etic categories if emerging themes were already represented in the literature on eating disorders (Denzin & Lincoln, 1994).

Open coding takes place throughout the data analysis process, but is also the starting point for grounded theory researchers. Through comparison and asking questions, phenomenon are given labels. In this way, the data is broken down into meaningful units (sentences, paragraphs) and examined for similarities and differences. Concepts that are similar are labeled under the same code at the same time as new data are being examined. Unrelated concepts are given different labels. Essentially open coding involves asking and answering the question: "What is going on here?" As the answer to this question

evolves concepts are changed and modified. Eventually, some concepts can be grouped together to form a category because they relate to the same broader concept or phenomenon. A category is conceptually more powerful because it is more abstract and pulls together ideas and concepts (Corbin & Strauss, 1990; Strauss & Corbin, 1990). Open coding is designed to expand the researcher's way of thinking about the data while axial coding is the beginning of integrating the data (Rafuls & Moon, 1996).

Development of codes and categories. Procedures outlined in Strauss and Corbin (1990) on using grounded theory were followed for this study. Coding began with session one by comparing similarities and differences between incidents. Open coding was done by reading the transcripts line by line and breaking down the data into meaning units. These units of meaning were then labeled by asking the question: "What does this unit represent?" Codes were established to reflect as closely as possible the substance of what was said while remaining true to the words of the participants. Essentially this process of open coding was the beginning of category building.

Recurrent themes and patterns were noted even in the first session as open coding proceeded. Thus, tentative clusters of codes were labeled as categories for the first session. The following 13 sessions were studied and coded in a similar fashion. Familiar codes were placed in already existing categories and new codes and categories were developed for different themes and ideas to account for the new information.

Axial coding takes place after open coding because it involves "a set of procedures whereby data are put back together in new ways... by making connections between categories" (Strauss & Corbin, 1990, p. 96). Axial coding relies on a paradigm

model to elucidate the category in a number of different ways. First, causal conditions refer to the events that lead to the development of a phenomenon as defined in open coding. Second, the context is a description of the properties that pertain to the environment. Strauss and Corbin (1990) define context as "the particular set of conditions within which the action/interaction strategies are taken ..." (p.96). Third, action strategies refer to the methods that are devised to handle, manage or carry out events (Strauss & Corbin, 1990, p.96). Intervening conditions can facilitate or constrain the strategies or action taken: "These conditions include: time, space, culture, economic status, technological status, career, history, and individual biography" (Strauss & Corbin, 1990, p.103). The final component of the paradigm model is the consequences. Consequences refer to the outcomes or results of action or inaction. It is through the use of this paradigm model that the nature of the relationship between subcategories and categories is tested and verified (Strauss & Corbin, 1990).

The foundation for selective coding is done through the process of axial coding. The paradigm model is also used for selective coding but at a more abstract level. Strauss and Corbin (1990) define selective coding as "the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development" (p. 116). Basically, the researcher must select and name a central phenomenon (core category) and explain how all the other categories relate to it. The central phenomenon is at the heart of the integration process and is essentially the basic social process that is being studied (Rafuls & Moon, 1996). The paradigm model is used in the same manner as it was with axial

coding, except instead of relating sub-categories to categories, selective coding connects categories to the core category through causal conditions, context, action strategies, and consequences.

Linking the categories. The researcher used two strategies to link the categories together: theoretical memo-writing and selective coding using the paradigm model. During data analysis memos that posed questions about possible relationships were kept in a journal.

Selective coding became the cornerstone for theory building. The paradigm model allowed the researcher to ask questions about relationships: Under what conditions is the eating disorder likely to flourish? What strategies or actions have women taken to enable them to cope with or fight against the influence of the eating disorder? In what contexts does the eating disorder gain advantage? In what contexts do the women overcome the influence of the eating disorder? What are the consequences of living with an eating disorder? What are the consequences of fighting against the influence of the eating disorder? Basically, existing categories were examined in relationship to the questions outlined in the paradigm model.

Eventually, through constant interaction with the data, a core category and related theory emerged. The theory was checked against the data a number of times to be sure the theory was grounded in the words and experiences of the participants. Further, the other facilitator of the psychotherapy group and my supervisor were consulted about the appropriateness of the theory. This tentative theory now needs to be tested with other people in other settings to ensure its utility.

Outside of coding procedures, a number of researchers stress the importance of theoretical memos as imperative to grounded theory analysis (Corbin & Strauss, 1990; Rennie et al., 1988; Strauss & Corbin, 1990). Theoretical memos are important throughout both data collection and analysis in order to highlight ideas, ask questions, and identify areas that require further examination. Memos are instrumental in helping the researcher think beyond the single incidents to more speculations, patterns and relationships (Rennie et al., 1998). Memos are not normally included in the formal write-up of grounded theory but function to point out where relationships are weak or concepts need more elaboration. Memos are a fundamental part of the formulation and revision of the theory during the research process (Corbin & Strauss, 1990). Finally, memoing helps the researcher to declare bias openly and thus decrease the influence of the bias into the research. Memoing not only increases the richness of the resulting theory, it increases theoretical sensitivity. Memos were used throughout this study and became a fundamental part of theory building.

.Evaluation of Trustworthiness

Most qualitative researchers would agree that criteria for evaluating quantitative research are inappropriate for the evaluation of qualitative research; at least to the extent that basic canons need to be modified for use with qualitative studies (Henwood & Pidgeon, 1992). Quantitative evaluation criteria is based on the notion that there is one acceptable, ultimate reality or truth that can be discovered through use of the scientific method. In contrast, qualitative researchers in general adhere to the idea of multiple,

constructed realities (Sandelowski, 1993). Thus, the criteria to evaluate these two paradigms in order to be useful needs to be suitable to the underlying assumptions.

A number of researchers have modified ideas based in quantitative research to better suit evaluation of qualitative studies (Hall & Stevens, 1991; Sandelowski, 1986). Quantitative methods of internal validity, external validity, reliability and objectivity have been translated to evaluate trustworthiness in qualitative studies through credibility, transferability, dependability and confirmability. These four qualitative measures are described below along with an explanation of their application to this study.

Credibility

Internal validity in a quantitative paradigm requires that the researcher take steps to be sure that the study is indeed measuring what it claims to measure (Sandelowski, 1986). Indeed, variation in the study should be accounted for by manipulation of the independent variable and implies a linear/causal relationship between variables. However, because qualitative researchers do not assume there is an objective reality, internal validity is not an appropriate measure.

Credibility in qualitative research requires that the interpretations of human experience be faithful to the lived experience of the participants in the study. There are a number of methods that qualitative researchers can use to achieve credibility. Glaser and Strauss (1967) suggest that the constant comparison method is designed to enhance credibility. Similarly, Strauss and Corbin (1990) consider the systematic procedures for analyzing data a means to demonstrate and facilitate the theory deriving directly from the

data. This study employed both the constant comparison method and systematic data analysis.

Sandelowski (1986) also suggests prolonged engagement as a tool to enhance credibility. The building of rapport and establishment of a trusting relationship was facilitated in this study by group therapy meetings, which were held once a week for 14 weeks. The relationships that were established over this time period helped to ensure a cooperative process and increased the credibility of this study.

Transferability

External validity is to quantitative research as transferability is to qualitative research. In a positivistic paradigm, the applicability of a study is determined by how well external validity has been controlled. Essentially, this concept refers to the generalizability of the findings. In qualitative research the generalizability of the conclusions to other settings is called transferability. Kvale (1996) identifies three forms of generalizability: naturalistic, statistical and analytical. Firstly, naturalistic generalization refers to personal experience and this personal knowledge and experience leads to expectations. In this study, the researcher used her personal experience to produce explicit propositional knowledge as outlined in Chapter Two. Secondly, statistical generalization refers to the use of inferential statistics to generalize from the selected sample to a larger population. However, in qualitative research interviews, subjects are seldom selected at random but rather through self-selection. Self-selection can lead to valuable knowledge about personal experience but cannot be generalized to the population at large. Thus, in this study, the self-selected sample of women with eating

disorders seeking help through group therapy may provide valuable knowledge about this group of women but cannot be generalized to the general population. Thirdly, analytical generalization involves a reasoned judgment about how the results of one study can be used to guide another. Thus, in this study it could be argued that the results of this study could be used as a guide for other psychotherapy groups for women with eating disorders. The reasonableness of this generalization rests upon the richness and thickness of the description of this group experience.

Grounded theories are intended to uncover unique phenomenon and generate hypotheses for future investigations (Glaser & Strauss, 1967). Because there are multiple realities, every research study is unique to that interaction in that particular context. In feminist research external validity is not a desired quality because human experiences are unique and not necessarily repeatable (Hall & Stevens, 1991). Other theorists concur that it is not the qualitative researcher's task to provide transferability across times and contexts (Henwood & Pidgeon, 1992; Sandelowski, 1986). Rather, a well-integrated and rich description of the theory is fundamental so other researchers can make their own judgements about transferability. This study provided a rich description of the grounded theory and utilized an audit trail to guide the research process.

Dependability

In quantitative terms, reliability means repeatability. However, because qualitative research studies the unique and contextualized experiences of people (Hall & Stevens, 1991), reliability is an inappropriate construct. Dependability is a term that better describes establishing trustworthiness in a qualitative study.

There are a number of ways to achieve dependability. Hall and Stevens (1991) suggest that use of multiple data sources and observers as well as a clear trail concerning decisions about the study from beginning to end (auditability) are useful tools (Sandelowski, 1986). In this study, the researcher met frequently with colleagues to discuss rationale and decision making processes. Utilization of a large literature pool during the analysis also provided alternate sources of data in this study. Finally, documentation in the form of transcripts, and memoing journals used from the beginning of data collection through completion of the study can be provided on request.

Confirmability

Objectivity is a notion that is aspired to in quantitative research. However, objectivity, according to some researchers is neither achievable nor desired (Sandelowski, 1986). Rather confirmability refers to the criteria of neutrality in qualitative research. Confirmability is also achieved through an audit trail but in addition, can include reflexive journal writing. Reflexive writings may include information about self, concerns and biases, and a tracking of decisions (Sandelowski, 1986). Reflexive writings were included in the journal of the researcher throughout the process of this project.

Summary

This chapter provided an overview of a grounded theory strongly influenced by feminist principles. The purpose of the study and an overview of grounded theory set the stage for a more detailed look at the methodology used for the current study. Grounded theory procedures including theoretical sensitivity, theoretical sampling, and data collection were explored with attention to the application of this project. Lastly, a step by

step account of the data analysis procedures preceded a discussion of the trustworthiness of this study. In the next chapter, the results are presented in the form of a grounded theory for this project.

CHAPTER 4: THE GROUNDED THEORY

This chapter provides an outline of the grounded theory generated through the analysis of fourteen weeks of group psychotherapy. It is organized into three major sections. First, the core category will be briefly explained. Next, the remaining categories and their properties will be outlined and described, **Phase I** and **Phase II**, respectively. Special attention will be given to safety and the contribution of the reflecting team at each phase of the model. Lastly, the paradigm model (Strauss & Corbin, 1990) is explored in more detail to illuminate the connections between the phases and categories. The results will be illustrated by the words of the women in the psychotherapy group and in the reflecting team, thus grounding the theory in the actual data.

The theoretical model aims to account for the interaction in group therapy where women move toward recovery from an eating disorder. Themes were uncovered from the data through the process of coding described in Chapter Three. Some themes emerged directly from the words participants used to describe their experience. Other code names were derived from the researcher's experience with the data. The large amount of data were managed using Strauss and Corbin's paradigm model (1990) described in Chapter Three. After open coding, connections between categories were illuminated by placing the themes into the paradigm using causal conditions, context, action strategies, intervening conditions, and consequences (Strauss & Corbin, 1990). The paradigm model provided structure to the enormous amount of data available and provided a way of evaluating which themes were central to the experience of the women in the group.

The Grounded Theory

The grounded theory model derived from this data involves two phases that are related to each other temporally. However, **Phase I** and **II** can occur in the same session, or in the same minute for that matter. Thus, these phases occurred not linearly but circularly with the generalization that **Phase I** occurred in sessions 1 to 7 and **Phase II** occurred in sessions 8 to 14. The interaction of the psychotherapy group involves **Phase I: The Influence of the Eating Disorder on Life and Relationships**, followed by **Phase II: Important Factors in Overcoming the Eating Disorder**. The movement of the group from one phase to another was dependent on the level safety in the group. Common themes associated with each phase were identified and are outlined below.

Core Category

The paradigm model described above was also utilized for the selection of a core category. Recall from Chapter Three that the core category is the central phenomenon or the basic social process being studied. The central phenomenon became clear through asking questions about the connections between categories. It became apparent that the movement of the group from one phase to another was dependent on the level of safety in the group. Safety, a basic sense of trust and security or being safe from danger or damage, was the overarching framework within which the group functioned. When safety was low the group tended to discuss the eating disorder and its influence. When safety was high the group then discussed strategies about how to overcome the influence of the eating disorder.

Phase I

Safety

It seemed when safety was low in **Phase I**, a lot of discussion about safety and long silences ensued. For example, one participant expressed her need for safety in the group, "...[O]ne of the reasons why I'm scared to say anything is the fact that I need to express it in a place where I feel - where my expression is secure." Another participant expressed her frustration with the silences in group, "Or even us as a group... for us to be in a circle and have nothing to say or not to be able to overcome the fear, get vulnerable enough to share, it just means the disease wins again." The group seemed to have to return to a discussion about safety a number of times before safety became apparent in the group interaction. Thus, the safety of the group was discussed throughout **Phase I** but not practiced consistently until **Phase II**.

Influences of Eating Disorder On Life and Relationships

During **Phase I**, the safety level was related to discussion about the eating disorder and its effects on the lives of the individuals and the interaction of the psychotherapy group. Two major categories emerged from this interaction, **SELF-IN-RELATION** and **SENSE OF SELF**. Minor categories and properties also emerged and will be discussed and illustrated below. The categories, sub-categories and properties of **Phase I** are summarized in Table 1.

Table 1

Influence of Eating Disorders on Life and Relationships

Categories	Sub-Categories	Properties
Self-In-Relation	Seeking Self	comparison with others wearing a façade only giving to others everyone must like me unable to be in moment
	Lonely Self	destroys social life isolation hard on relationships can't trust self or others being secretive
Sense of Self	Negative Self	consuming negative thoughts self blame and guilt negative body image worthlessness/not deserving self-doubt
	Empty Self	empty/drained time and energy consuming avoiding feelings
	Paralyzed Self	feeling out of control builds fear high expectations perfectionism difficulty with decisions

Self-In-Relation

Much of the discussion about the eating disorder and its influence centered on the relationships or lack of relationships developed by this group of women. Two minor sub-categories emerged from the self-in-relation category.

The seeking self. The **seeking self** emerged as a sub-category of **SELF-IN-RELATION** as the person never seemed to be satisfied with who she is in the moment. Five properties of this sub-category illustrate the qualities of the seeking self. First, the property **wearing a façade** was illustrated by a number of participants: "...I always kind of put on a front and everyone thinks I'm that way but then when I get home and I'm alone – I know that I am the total opposite... But I like everyone to think I'm that way." "Like I know I can't fix what's inside here and what's right now, so I'll fix everything else and make everything look great to everyone else's eyes." "...[P]erfect on the outside but a mess on the inside." "I perceive others perceive my body looks fine but I know the degree of unwellness inside myself. So it's like a façade all the time." The word **façade** was chosen because a number of participants used it to describe their experience in relating to others. It seems participants felt they had to put on appearances and be something or someone other than herself in order to carry on relationships with other people.

The second property **comparison with others** seemed a powerful property for the members of the group evidenced by the frequency and emotional quality of discussion around this theme. Examples of this are: "I've always compared myself to somebody else and therefore see myself as not perfect." "But still I feel I'm not qualified to be a part of

this world, if this makes any sense, cause I don't feel that I – I live up to what is considered ideal, beautiful." "I'm afraid in comparison to everyone else I'm going to be the one that's the largest and singled out." Again, the comparative component has a quality of striving for something else or feeling less than as is. This property of the **seeking self** was particularly salient in the group in **Phase I** as members seemed to literally size each other up to be sure they were not the largest body in the group.

Thirdly, **only giving to others** was a common language the members of the group identified with: "I would get myself so wrapped up in her problems because I, I couldn't deal with my own." "I started to write down all the things I did in a day, everything I did, and that was for other people...there's nothing here for me." "I'm trying to sort out both my life and my friend and my family's life..." "And I'm always there, you know, like picking her up and saying, you know, life is going to be okay...the person who is losing out is me." Relating to others by only giving and not accepting or receiving from others seems to be an effective tool for avoiding self. Additionally, the assumption all people are seeking and are unhappy with their present situation underlies this property of **only giving to others**.

The fourth property is a rule that the members of the psychotherapy group agreed the eating disorder influences– **everyone must like me**. This rule is illustrated through the participant's voices: "I'm just always so concerned about people liking me and people agreeing with how I do things." "I was always driven by my approval from other people. It was never okay to just be wherever I was at." "I've had that all my life where I've always felt that I had to please everyone and have everyone like me..." It seems then that

it is not enough to be in relationships with people, rather, every person significant or not, must think highly and approve of her actions. This stringent rule seems to imply that if someone takes dislike or disapproves that the group member must change something about herself to make the relationship better.

The final property of the **seeking self** is an **inability to be in the moment**. Examples are: "I find it very difficult to live day by day. I'm very focused on the future." "Like I find even tonight I'm thinking of where I have to be after this. And it keeps me from being present here which keeps me from feeling close..." "...[Y]our mind, you're preoccupied, you're not where you are and you're not living your life to the best of your ability. You're off somewhere else, you know." Thus, it seems that even when in relations or communications with others, that the **seeking self** is unable to fully appreciate or experience the interaction. The overall quality of the **seeking self** seemed to be an inability to be in and enjoy the here and now as the **seeking self** is looking to make someone or something better in order to take the focus off self.

The lonely self. The second subcategory that emerged from **SELF-IN-RELATION** is the **lonely self** and it consists of five properties that will be illustrated through participants' words. The first property of the **lonely self** is that the eating disorder **destroys social life**. The participant's voices can be heard through the following examples: "I withdraw from people and try to get myself together." "It hindered me from having any real social connection." "I just want to push everybody away." Thus, having an eating disorder results in a dearth of social connection or interaction. **Isolation** is the second property of the **lonely self** and is closely related to the lack of social life indicated

above. Examples include: "It (the eating disorder) totally just hinders me from like interacting and connecting with people and I isolate myself." "And you just keep people from getting close to you." "I think it has to do with the isolation thing. Like, you know, we go through our days, and probably all of us keep the secret to ourselves for the most part. The eating disorder isolates you and of it keeps you quiet it's isolating you again from getting close to people." Physical and emotional isolation prevents any meaningful connections with other people and it seems that eventually the only constant is the eating disorder.

The third characteristic describes how the eating disorder is **hard on relationships**. Participants share their difficulty with relationships in the following examples: "I mean it's torn my marriage apart." "My husband thought it was his fault." "My challenge has been sorting out the new relationship that I have in my life and keeping that in a safe area. So I've had lots of different feelings and anxieties about that." Fourthly, **lack of trust for self or others** is an important property of the **lonely self**. Examples are: "I can't trust myself anymore, never mind trust anyone else..." "Like if somebody does something nice for me then I owe them, or it's always conditional." These two properties of the **lonely self** speak loudly to the lack of support and essential connections in the group members' lives. If the eating disorder is **hard on relationships, isolates** and **destroys her social life**, it is not surprising that it is difficult to trust or establish intimate relationships.

Finally, **being secretive** is an important dimension of the **lonely self**. This secrecy is shared by the participants: "I just feel like I'm being deceitful somehow by not letting

him in on that part of my life." "The fact that I am so worried about people finding out that I am in therapy." "He has been aware of the fact the I have an eating disorder but he hasn't really known the details or the history." " I just realize that this man that has become a very important part of my life, I haven't even told him that I have an eating disorder. I'm not sure why that is." Keeping secrets can be a lonely experience and a secret the size of concealing an eating disorder from others is no exception. The **lonely self** seems to have an overall quality of being unable to make meaningful connections with people resulting in a lonely and often alone self.

Sense of Self

The other major category that resulted from the interactions around the influence of the eating disorder on lives and relationships was **SENSE OF SELF**. Generally speaking, the **SENSE OF SELF** can be described as how each woman in the group felt about her being. This category differs from **SELF-IN-RELATION** in that the qualities of the **SENSE OF SELF** are more internalized. Three subcategories were uncovered through an analysis of themes and included the **negative self**, the **empty self**, and the **paralyzed self**.

The negative self. The **negative self** consists of five properties. The first property that was pervasive throughout all of the sessions was **consuming and distorted negative thoughts**. This aspect of the **negative self** seemed pervasive to all members of the psychotherapy group: "...[M]y head started playing games on me. It said – made the worst case scenario out of every single thing in my life all of a sudden. I mean a problem for me is like the world is ending. The smallest little thing can be like catastrophic." "My

thoughts just say: well, you know, there is no way you can do that so why even bother." "...[L]ike negative thoughts and stuff that I don't deserve this and .. I'm gross and all this kind of stuff." Group members often talked about two separate voices in their head and the negative voice (the eating disorder) seemed to be both persistent and convincing.

Self-blame and guilt is the second characteristic of the **negative self**. This property is illustrated by a number of participants: "It's all my fault, it's always going to be my fault so why bother trying." "...[S]o then I just take total one hundred percent blame and that then just kind of feeds the, the illness, you know, just starts that whirlwind blowing." "My biggest challenge is dealing with the guilt I feel about- like I feel guilty that I'm not- like I'm not taking care of other – these people that are in my life right now." " I find that it's in my daily routine and always feel guilt." " Guilt just serves to beat me up... if I feel guilty, then I – it feeds the eating disorder for me and I feel guilty about feeling good, feel guilty about feeling shitty, feel guilty about trying to be good..." It seemed guilt served to reinforce the negative attitude toward self as there is no way out because nothing is ever good enough. The self can never be good enough to not warrant guilt or blame.

The third characteristic of the **negative self** is **poor body image**. Body image seemed to be a particularly charged issue that was closely related to safety. When a body image exercise and discussion was proposed in session 2 the group retreated: "I think I feel very afraid to do that because I think that, I don't know, I have a real distorted body image." "It sets off panic because you see picture of yourself and it's not what you want or you thought and you're going to sabotage that too." "It (the body image exercise) just

feels so threatening." "Everything is body image. And I just don't want to see it." "It's not about whether my butt is bigger, my hips are smaller, my waist is smaller, whatever, it's about the fact that I feel like it's not acceptable to me or that you know, I have problems about the way I feel about how I look." Body image seemed to constitute a large portion of the group's sense of self. The impact of **body image** on **SENSE OF SELF** seemed more powerful and emotional than any other property of the **negative self**.

The fourth property of the **negative self** is **a sense of worthlessness/not deserving**. Examples are: "I find myself thinking I don't deserve this, I don't want this, good, I'm going to do nothing, poor me..." "I feel like I'm less than and I don't deserve anything better." " I still feel I'm not qualified to be a part of this world..." The final characteristic of the negative self is **self-doubt**. Participants express this property in the following examples: "I have no confidence anymore in myself, I feel I'm going to fail at everything." " And then its all this self-doubt comes in and it's like, well, is that the right decision... it's like this tatter going on in my head." " And that I'm just afraid of how I'm going to deal with things, like how much I can handle." These two properties speak loudly to lack of positive characteristics attributed by the group members to their sense of who they are or can become. The **negative self** seems to be characterized by an overall quality of disallowing or rejecting any positive attributes of self whether it be a thought, feeling, action, or characteristic.

The empty self. The **empty self** consists of three properties. First, **feeling empty or drained**: Examples include: "And sometimes I don't have the strength or energy..." "I'm starting to fold physically and just getting too tired to do it." "...just totally

exhausted." It seemed there was a feeling of having nothing left. Secondly and closely related, the eating disorder is described as **time and energy consuming**. This property is illustrated by participants: "You know one day I might want to be really athletic and be able to be like the most fit woman that there is and the next day I just – I want to be the skinniest person that there is." "It (the eating disorder) requires a lot of energy and a lot of time." "It is very time consuming." Thus, it seems that if there is anything in the self it is something about the eating disorder. Lastly, the **inability to deal with emotions** characterizes the **empty self**. Emotions were discussed by the psychotherapy group: "And that triggers conflicts or feeling that come up, I just don't know how to deal with it." "I can't do this anymore – get this feeling." "Like I was medicating myself on food so intensely for the last 8 - 10 years that I don't know if I ever felt much from childhood into adulthood." "It's the fear that the feeling would start and never stop." The perceived inability to deal with emotions results in efforts to do anything to avoid feeling. The **empty self** seems to be an overall sense of hollowness or a void within the individual. Most time and energy seems to be taken up giving life to the eating disorder and anything unfamiliar, like emotions, seems unmanageable. An empty echoing ache resounds and the empty self sees herself as nothing.

The paralyzed self. The third sub-category of the **SENSE OF SELF**, the **paralyzed self**, is characterized by five properties and left the women in the group immobile. One participant expressed her **paralyzed self**: "And when I carry it (eating disorder) around myself it's almost like it's overwhelming... I just think it's so huge it

paralyzes me." At some points in the psychotherapy group, the group itself also seemed paralyzed.

The first property is **feeling out of control**. Examples are: "Control. Fear of losing control. Like it's a control thing. Like, I – it's like giving in." "It's like a control thing too, you know, if you feel like you are losing controlling a situation or something in your life, here we go, this is my way of gaining control." "I feel that I'm not taking control and I feel that other people are controlling my life for me." The **paralyzed self** seemed to get stuck around the issue of control because the eating disorder allows her a sense of power and control when everything else seems beyond her immediate control. This false sense of control was perhaps somehow appealing.

The second characteristic of the paralyzed self is **fear**. A number of fears were expressed by the participants: "But it was fear of rejection or fear of embarrassment or fear that the shame would be greater than my ability to cope with it." "I just don't like to get too close because I have a fear of them leaving too, a fear of like losing them." "Like I'm afraid of failure but I'm also very afraid of success, of actually getting where I want to be in life because like what if I did get there; what now?" **Fear** also seemed to render the group members immobile as facing fears of abandonment, rejection, success, and failure brought them face to face with themselves.

The third property of the paralyzed self is **high expectations**. These expectations seemed to affect both self and others: "I know that it's kind of like self-defeating because I have really high expectations of myself and of others." "For me, I don't have a fear of change as much as I have a fear that I'm changing too slowly and that I don't do enough

and the eating disorder can catch up with me." A closely related property, **perfectionism**, was frequently discussed throughout the group: "That's how I see this disease for me. I'm always living in the extreme – it's black or white." "Everything has to be either this way or this way and there's no in-between." "And I used to go ballistic. I used to go absolutely awol if things weren't perfect, you know." "It's like never good enough. There's no limit to perfection, you know." "I can stand in front of the closet for like an hour and I can never find the right outfit, it's not good enough...it's gotta be perfect." Perfectionistic expectations set up the group members for paralysis because why move forward when you know it is impossible to ever get there?

Lastly, the **paralyzed self** is characterized by **difficulty with decisions**. This property is illustrated through participant voices: "But then if there is a choice to be made I can't do it myself, I have to ask other people's opinion." "I have personally right now two very difficult decisions I have t make very quickly and I really don't know whether I'm coming or going." "I waited till the last minute and whatever decision is left, I go there...and the reason why I do that is because I'm afraid what choice to make because if it's the wrong choice I want a way out of it...and also my decisions are based on other people." Again, a sense of selflessness or lack of self makes decision making virtually impossible. The **paralyzed self** seems to render the women in the group frozen and defenseless.

Phase I of the psychotherapy group focused mostly on the influences of the eating disorder on life and relationships. The two major categories that emerged in this phase

SELF-IN-RELATION and **SENSE OF SELF** were also uncovered in the analysis of the reflecting team's discussion.

Reflecting Team's Contributions

As introduced in Chapter Two, the reflecting team watches the group interaction from behind a one-way mirror. At the end of the group the reflecting team enters the room, sits in their own circle, and discusses their observations of the psychotherapy group. The reflecting team seemed to be a mirror image of the group as their separate discussions revealed the same core category, categories, and subcategories. In addition, the mirror image that was reflected back to the psychotherapy group usually added suggestions, observations, curiosities, alternatives, support, or praise. As mentioned above, in **Phase I** there seemed to be more focus on talking about the eating disorder influences. This focus was noted by one member of the reflecting team in week 2, "...[T]he goals are all about weight or behaviors and I'm wondering how it would be different for the group members if the goal was something that didn't seem to relate to the eating disorder." Illustrations of the reflecting team's contribution to **Phase I** are provided below.

Safety. The reflecting team's role at this phase seemed to focus around **pushing safety** by challenging the group to speak up and take more risks: "I guess I feel sometimes that the group is being selective about what they share with one another and it's almost as if sometimes they're just staying in an area where they feel safe, where it's comfortable for them." "I just wonder what might encourage a greater range of discussion." Safety was a central theme throughout the comments of the reflecting team

in **Phase I** as comments about the process of the group often related to the safety of the group as a whole. Thus, the reflecting team held up a mirror in terms of the content of what the psychotherapy group was saying. In addition, the reflecting team would comment about on here-and now behaviors of the group and the immediacy of the relationships in the psychotherapy group.

Self-in-relation. The reflecting team often commented about group interactions and process. For example, in week 2 when the psychotherapy group retreated after a body image exercise was suggested, one reflecting team member wondered about the process of the group's decision making in relation to the theme of **seeking self**: "I wondered what impact the eating disorder had on their group thinking about whether they would participate or not. How did that feel like to be going against what someone else feels?" Aspects of the **lonely self** were also commented on by the reflecting team: " I noticed that **isolation** was a tactic that was identified as something the eating disorder used and I noticed that a lot in the group and I wondered if there's anyway the group can work together to challenge the eating disorder against the **isolation**." The discussion of the reflecting team, although reflective of the content, focused more on the way the group managed its interactions.

Sense of self. Again, because the reflecting team is literally a reflection of the group's interaction, it is not surprising that separate coding of the reflecting team's interaction resulted in virtually the same categories. For example, all three subcategories of **SENSE OF SELF** were reflected in **Phase I** of the reflecting team. First, the **negative self** was reflected back to the psychotherapy group by the reflecting team: "...I wonder

what putting on the label of 'eating disorder thinking' does in terms of keeping them from maybe being open to appreciating segments of positive thinking that my be present that are either being ignored or shut down." Secondly, the **empty self** was challenged by the team, " ...I wonder what it would feel like for them to give in to the feelings that they have and fully embrace them instead of running away from them or trying to shut them down or eat them away..." Finally, the **paralyzed self** is offered a suggestion by the reflecting team, "...[B]ecause I think a lot of the times the eating disorder, that the power of it is that you don't know where you're at with it. You don't know when you're experiencing eating disorder behavior and when you're not. And so being able to identify is the great thing, to be able to capitalize on that." Overall, the reflecting team served to reflect the group content illuminated from a different perspective.

Parallel process. There seemed to be a parallel process between the psychotherapy group and the reflecting team. For example, as safety increased in the psychotherapy group, interaction increased and lengthy monologues decreased. The same general pattern occurred in the reflecting team's discussions. As the group progressed, the reflecting team started to interact more with each other and build upon each other's ideas rather than relating as separate individuals jumping from one topic of conversation to another. A number of other parallel processes will be discussed in **Phase II** below. Figure 1 provides a diagram of how safety, influences of the eating disorder on life and relationships, and the reflecting team function in **Phase I**. During the time when safety was low, the diagram shows the focus on **SENSE OF SELF** and **SELF-IN-RELATION** properties. The reflecting team is in the middle of this diagram trying to **push safety** outward to

become bigger than the psychotherapy group and the eating disorder. Properties that are farther away from the center seem more threatening or less safe for the group. For example, it was easier for the group to talk about **food and weight** than to discuss **body image.**

Phase II

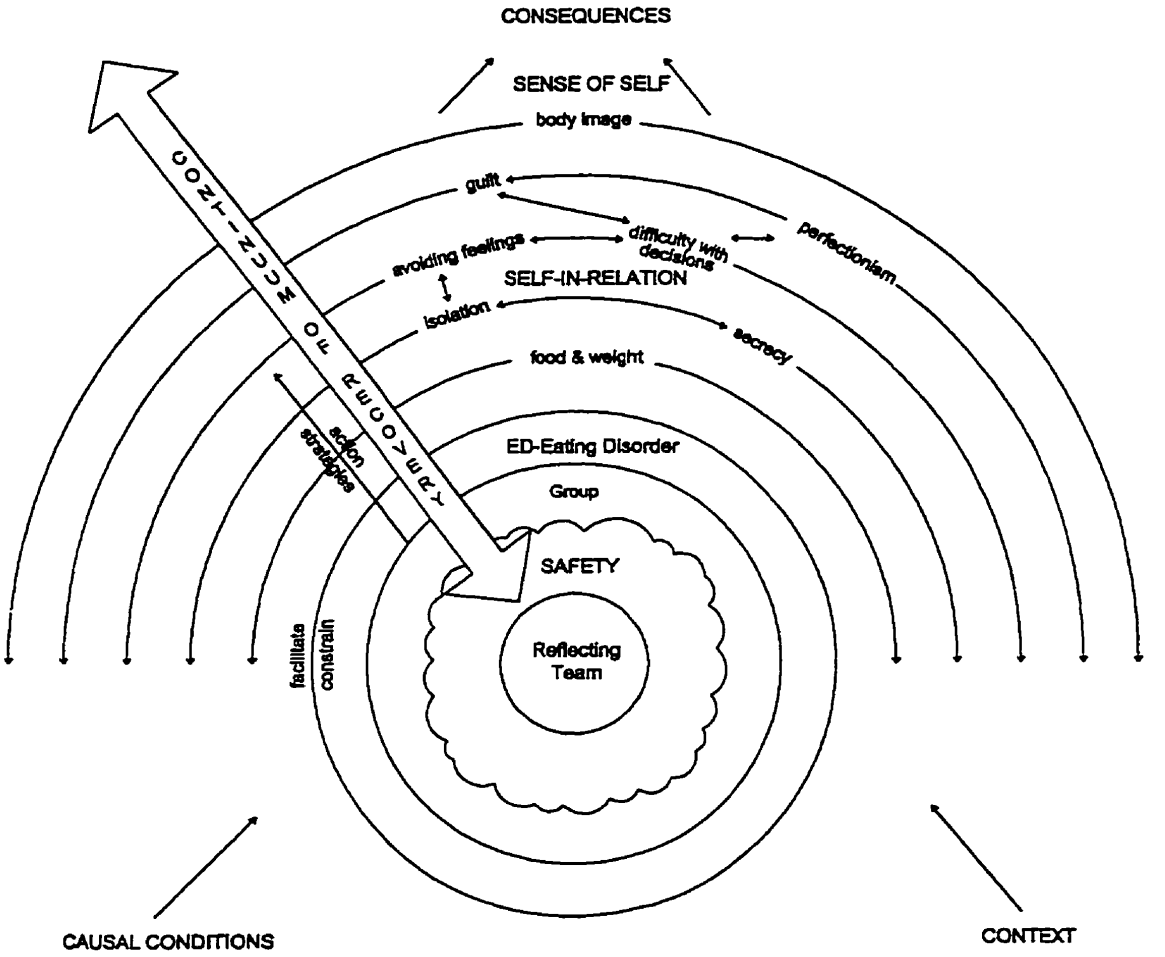
Phase II of the psychotherapy group focused more on important factors in overcoming the eating disorder. This phase of the group began around session 8 and continued through to session 14.

Safety

As the safety of the group began to increase, the majority of discussion shifted to focus on strategies to overcome the eating disorder. For example, group members commented about feeling safe in the group: "And then I come here and like everyone's dealing with so much stuff and it, you know, sometimes it makes my problems seem quite small. It also makes me feel quite good that, you know, I have problems and I'm dealing with them and also that everyone has problems and everyone's just doing the very best they can..." "I don't know if it's because we're all feeling more comfortable that we're sharing more, that we're – I feel like we're getting somewhere." At the beginning of **Phase II** the psychotherapy group seems to request that the focus be more on strategies: "Now I don't know if time would permit to do it in a group...is to take your challenge and do some brainstorming with that idea or attempt some type of problem-solving exercise." In short, **Phase I** focused on the eating disorder and **Phase II** focused on overcoming the eating disorder. Overall, the quality of **Phase II** is much more active,

Figure 1

Phase I: Influence of Eating Disorder on Life & Relationships



unlike **Phase I** which focused on talking about instead of practicing or experiencing issues.

Important Factors in Overcoming the Eating Disorder

Three major categories and 6 sub-categories emerged from the data through discussion about how to overcome the influence of the eating disorder. Many of these strategies were practiced outside of the group. Additionally, many of these strategies were practiced and experienced in the group. A summary of the categories, sub-categories and properties is illustrated in Table 2.

Differentiate Self

The focus of **Phase II** was on action strategies to overcome the eating disorder. Seeing self as a separate individual seemed an important strategy in some contexts. Two sub-categories of the **DIFFERENTIATED SELF** are discussed below, the **unique self** and the **assertive self.**

Unique self. The unique self includes three strategies to overcome the influence of the eating disorder. First, the unique self **critiques the media.** Examples include: "And high expectations of yourself, you know, due to society and blah, blah, blah. And how is that – and how that has created or influenced the unrealistic women." "But just the way ideals have become not sensible... Models, they smoke and stuff because it's an appetite suppressant and look at them, you know, like lung cancer and all that stuff." The **unique self** is able to see advertisements and media images for what they are and place themselves outside of those unrealistic expectations. The second property of the **unique self** is the ability to **be accepting of differences.** Participants express the importance of

Table 2

Action Strategies to Overcome Eating Disorders

Categories	Sub-Categories	Properties
Differentiate Self	Unique Self	critique media be accepting of differences separate self from eating disorder
	Assertive Self	speak your mind put self first take credit
Balance Self	Thinking Self	change negative thinking see middle ground make goals smaller power of choice
	Active Feeling Self	be honest with self be willing to grow up take action self-care
Connected Self	Present Self	support from friends and family be in the moment confront others with issues
	Social Self	be with people who understand break isolation more social interaction

this strategy: "It also helped me be a little more kind to people who are really obese or just overweight...I am much more understanding that – you know that that could be one of the ailments for me, so I understand." "So I've been spending the last long while trying to come out of that, like just accept people for who they are and just endure some aspects of them and myself. And I think it comes down to more me, you know, like that I'm not perfect and endure aspects of myself that aren't perfect. So, in that way, like, the better I get at doing that, the more I can accept others for who they are." The **unique self** is able to look at differences in herself and in others and accept and maybe even appreciate them.

The last property of the unique self is **separating self from the eating disorder**. This strategy seemed to be particularly powerful and impacted the psychotherapy group. "At least now I can recognize, like that wasn't me, no that wasn't me that was the eating disorder talking. You know, like it's kind of neat, like its just – kind of neat now to have a bit of the upper hand rather then the lower card." "But if I can separate myself from it you know, like that's the eating disorder talking, it wants to bring me to my knees. And that's what it needs to tell me to get power and strength over me, but I'm not like that, I don't need to be like that, that's not who I am. Like separating myself from it because then I stand a chance." The ability to see the eating disorder as a separate and distinct entity from **SENSE OF SELF** seemed fundamental as fighting to overcome the eating disorder is no longer then fighting against the self. The **unique self** is able to see both self and others as less than ideal and still find that acceptable. In other words, the **unique self**

can **DIFFERENTIATE** herself from others and her eating disorder and be okay in her uniqueness.

Assertive self. The second sub-category of the **DIFFERENTIATED SELF** is the **assertive self**. The first property of the assertive self is to **speak your mind**. Participant's words illustrate this: "I proceeded to tell him the whole nine yards..." "I told (my partner) that I couldn't go on the way things were going and so either you have to leave or you have to help me work on it." "I don't let people run all over me anymore without saying anything. I used to never say anything. Now I stick up for myself or I start to or try to." The **assertive self** is able to identify a position or opinion and state it. A related property of the assertive self is to **put self first**. Examples of this property are: "...that I'll look out for who's number 1 and that's me and my kids." "I've been exercising more boundaries around my time...I've been over-accommodating everybody but me, so..." "I need to put my stuff first instead of putting everyone else's first." The ability to identify and meet one's own needs is a property of the **assertive self**. Finally, **taking credit and accepting compliments** is the last property of the **assertive self**. This aspect of the **assertive self** is illustrated through the words of the participants: "And I start to try to pat myself on the back and say, you know, I've done this – this – and this and that wasn't the eating disorder that did that – that was me." "...[B]ut I was able to stop and say, you know, and no, I do deserve to do something nice and this just, and it's OK for me to accept generous offers from other people." Instead of letting an opportunity to commend herself pass by, the **assertive self** acknowledges personal accomplishments and accepts praise from

others. Overall, then, the **assertive self** is able to stand up for her beliefs and opinions and take credit when it is due.

Balance Self

The second important factor and major category in overcoming an eating disorder is the **BALANCED SELF**. This category seems to be in the middle on a continuum between the **DIFFERENTIATED SELF** discussed above, and the **CONNECTED SELF**, to be discussed below. One participant expressed her balanced self, "If I allow myself to be with good people and enjoy good relationships, have fun in social situations, play and laugh and cry...If I'm willing to grow and change, if I'm willing to try something different...But to see myself be the best I can be, don't do any more, don't do any less." The balanced self consists of two sub-categories, the **thinking self** and the **active feeling self.**

Thinking self. The **thinking self** has four properties. The first and fundamental property was the strategy of **changing negative thinking**. The importance of this strategy is illustrated by the psychotherapy group members: "...[I]t's like a voice in my head... but I really have to stop it and say...like I'm not interested in hearing what you have to say...stop him in his tracks and turn my thinking around." "I just really say how negative thinking was around that and just stop it and be willing to entertain positive thinking around it." The group also brainstormed around the negative thought, "I'm so fat." One participant challenged this, "What about 'I feel fat' because like, I can feel angry or I can feel sad or I can feel resentment but that doesn't sort of mean that's who I am and then I have half a chance of moving to through and at some point it might end...you know if 'I

am fat' then it will take 6 months to get unfat, but if I just feel fat today, then there's certain things I can do to take that feeling away or maybe that feeling will pass." This statement is also an example of the second property of the **thinking self**, the ability to **see the middle ground** or the gray area. Other examples include: "Like I'm just eating little bits of things that normally I wouldn't allow myself any of." "...[I]t's kind of like he either loves me or he doesn't...Just kind of accept something in the middle and allow it to progress." Recognizing the gray area was a strategy that was useful for a number of different issues and brainstorming as a group provided a means for the group to recognize options other than the black or white alternatives.

The third strategy of the thinking self is to **make goals smaller/decrease expectations**. Participants share their experiences with this strategy: "...I do believe that when you're in recovery that you can be gentle with yourself and deal with one at a time, because I've had this whole series of problems and if I try to address then all in the same week it's not going to happen." "And it might not be, you know, what I'm supposed to or it might not be a good meal or whatever, but I'm eating it and so for me that's a big step." Making goals manageable seemed to actually increase the chances of taking action and finding success. The final property of the **thinking self** is recognizing the **power of choice**. Examples of this strategy are the following: "...[W]eighing my options and when I feel free, now I can make some choices." "I kind of get aware of it (eating disorder), you know. You do realize that you do have a choice." "There's empowering and disempowering. Power for me is a power of choice." The knowledge that there are choices seemed an important awareness never before considered by members of the

group. The **thinking self** centers around thought processes and practices tactics to combat negative or extreme thinking.

Active feeling self. The second sub-category of the **BALANCED SELF** is the **active feeling self**, consisting of four strategies. The first property is **to be honest with self**. Examples of this first strategy are: "If I reach out, tell people where I'm at, if I stay honest and not lie, just be true to myself..." "And if I don't open my mouth and stay honest and get outside myself, then it's just me and my disease against the whole world." The active feeling self finds a place where she can be honest with herself and others about her life. The second property of the **active feeling self** is a **willingness to grow up**. This strategy is directly expressed by the participants: "Commit to reality and be in it. You know life's in progress get in it... I think for me it took a lot of growing up – being willing to grow up." "...[B]ut it's the fear of getting out of like the security of my friends." "I can't depend on an outside person for my happiness or my care." "I know I'm thinking in a non-adult way of thinking." In some senses, the eating disorder serves as a cushion against responsibility. A **willingness to grow up** is a readiness to face responsibilities of real life adulthood head on. The third strategy is about being an agent – **taking action**. For example: "...[O]ne little step further, let's keep going on to try...let's try and act and go on." "...[T]he more you do it, the more and more you think that way then, yeah, it's going to become more of a habit and easier to do eventually." **Taking action** was a strategy utilized to encourage thoughts and feelings to follow. If the **active feeling self** lives life as if she is deserving, perhaps she would start to think and feel that way as well. Lastly, **self-care** is the final strategy for the **active feeling self**. Participants

agreed on the importance of this strategy: "Or if I take care of myself, I be gentle with myself..." "So I just became willing to do what I need to do to take care of me." "If I want to get pampered, I better get to it. And it doesn't feel any better to have someone else rub your feet." **Self-care** was an important strategy because many of the properties include a component that involves the body. Thus, self-care was a way not only to nurture the self and fight against the eating disorder, but also a way to start to connect the body. The **active feeling self** is an engineer of life and feelings and takes an active role in the fight against the eating disorder.

Connect Self

The third major category of factors in overcoming the eating disorder is the **CONNECTED SELF**. One participant expresses the importance of connection for her in her recovery, "Well, I think for me, one of the strongest parts of this disease is the isolation. When I get into it or get around food, then I stop relating to people and I stop reaching out and I stop sharing and then I start carrying everything...And getting outside myself seems to put it into perspective." There are two sub-categories to the **CONNECTED SELF**, the **present self** and the **social self**.

Present self. The first property of the **present self** is **support from family and friends**. Examples include: "...[T]hem coming and just accepting me for who I was and saying it doesn't matter what happened to you in the last couple of years, we still love you, we still enjoy having you around...I really didn't think anybody needed me anymore...I must be worth something." "It was a real help to have her listen and just to have her there knowing that I was safe." An important characteristic of this property is

that the **present self** is willing to accept the support from others and utilize it to her advantage. The second property of the **present self** is to **be in the moment**. This strategy is illustrated through the group discussion: "...[S]tart living for today instead of for last year and all the mistakes that we made." "...Or I'm in a group of people and never feel close to anybody or I'm in a conversation with somebody and I'm thinking of something else so I'm not really hearing what they have to say... it kind of keeps me from feeling connected or feeling like I'm participating in my life...I see it being important for me to consciously be present as a way of fighting the disease 'cause the disease wants me to separate away 'cause then that feeds the isolation which feeds my disease." The **present self** is able to be attentive and appreciate the moment in the here and now. The third and last property of the present self is to **confront others with feelings or issues**. For example: "I talked to my partner about it and got it all off my chest which I normally don't do, I normally stir in it for a long time." One participant confronted a facilitator in session 7 about moving on too quickly, "I just feel I need to say something...And I feel a little bit like jumping away from this topic and moving on, we're not honoring it and it's just like okay, that's a great idea but we'll talk about it next week." The **present self** has the ability to be in the here and now whether that means accepting support or protecting self.

Social self. The second sub-category of the **CONNECTED SELF** is the **social self**. The **social self** has three properties, the first of which is **being with people who understand**. This strategy made a difference to the members in the psychotherapy group: "It's like being here you can kind of relate, you know, in one way or another." "I think it's

made some changes because you're meeting people with the same sorts of problems as yourself and you're talking about it and that is change right there." "It's such a comfort to know that I'm not the only one going through this kind of struggle and there are other people that understand." The knowledge that you are not alone in the struggle seemed to be both comforting and empowering. The second strategy of the social self is to **break the isolation**. Examples are: "...[R]ather than not dealing with it or ignoring it on a day to day basis. Once a week you know you're going to group and they know about you." "It's nice to know I'm not alone you know." "And that's something (isolation) that feeds my disease in a big way. Just any length of time where I'm not checking in with people regularly." Taking steps to get outside the self and be in contact with other people seemed an important quality of the **social self**. The final property of the **social self** is to **increase social interaction**. This strategy is illustrated by group members: "I gotta keep people at regular intervals in my life to keep my disease in check." "I need to connect with people and I need to make plans for my weekends." It seems that practicing **SELF-IN-RELATION** is an important strategy of the social self. The **social self** utilizes caring people in their life to help combat the eating disorder.

Reflecting Team Contributions

In **Phase II** as the psychotherapy group began to focus more on important factors in overcoming the eating disorder, the reflecting team's consistent focus on action strategies seemed to take on more meaning to the members of the psychotherapy group. Action strategies for all three major categories were reflected back to the psychotherapy group. First, the **DIFFERENTIATED SELF** is illuminated by a reflecting team member:

"It's really hard to fight yourself. It's really hard to do that but if you can separate the two and see it as separate then this is another way to actually start to think about that and it really gives you a lot more control." Secondly, the importance of the **BALANCED SELF** in the middle of the continuum between **DIFFERENTIATED** and **CONNECTED** self became apparent through reflection: "...[J]ust anybody that cares about other people can so easily get involved with taking care of other people and forgetting to live for themselves...Because just the idea that we, even in order to better care for others, we need to have taken really good care of ourselves to begin with." Finally, the importance of **CONNECTED SELF** was apparent in the group process as when the reflecting team joined the psychotherapy group to make one larger circle instead of two separate circles, this connection seemed to facilitate more risk-taking and sharing. Additionally, the reflecting team made reflections about the **CONNECTED SELF**, this particular reflection a metaphor: "...[I]t's the idea of the eating disorder knocking on the door...and the image that came to me was almost with the person with their back against the door, their feet spread out and trying to hold the door against the eating disorder and it's still out there knocking. And the idea of support people then, coming and maybe bringing a lock that you guys could put on the door and that they could take turns with you holding the door. Or just the whole idea that if you have some people to help you that you're not just standing there alone fighting against the eating disorder." The reflecting team recognized and reflected back to the psychotherapy group the importance of a **DIFFERENTIATED, BALANCED**, and **CONNECTED SELF**.

Safety. Throughout the fourteen weeks but especially in **Phase II**, the reflecting team focused on the positive interactions or the risk-taking behaviors of the group members and offered congratulations when safety seemed to be high. For example, when one psychotherapy group member challenged the facilitator about moving on to quickly as mentioned above, the reflecting team offered praise. "I want to just mention that I thought it was really courageous of (group member) to speak up about what she wanted from the group and being sensitive to another group member's needs. I thought that was a really courageous thing to do and maybe it will just serve as an example to other members that that's okay to do in the group." Also, the team would comment on successes of the group as a whole, "...I really got a sense tonight that the eating disorder was being attacked." As in **Phase I**, comments about process focused on the safety of the psychotherapy group as a whole.

Transition from Phase I to Phase II. A major shift in the impact of the reflecting team happened in weeks 7 and 8. As a result of participant feedback, the reflecting team joined the psychotherapy group in their circle rather than having their own separate reflecting team circle. "I just don't understand why they can't come and talk to us..." This shift produced one larger group instead of two separate groups and seemed to increase safety. The psychotherapy group members commented on this increased safety: "I agree with appreciating them sitting with us and sharing with us... just having them as a part of the group was - - feels more respectable. And I was more open to hearing what they had to say and it was like I was invited to... So I was much more comfortable that was and I'm really glad we attempted that." "It was nice that they were in the group and

that, you know, it just seemed like everything was ok." The joining of the reflecting team and the psychotherapy group into one large circle during the reflections seemed to provide a sense of safety and connectedness.

Phase II. The joining of the two groups seemed to result in a number of important shifts. First, sharing of personal experiences increased in the reflecting team discussion. One reflecting team member made an important disclosure, "...[T]o share my experience of recovery...and I wouldn't say I'm at the completed end – recovered end of the spectrum, I'm somewhere in the middle." Not all members of the reflecting team had experienced an eating disorder but all had experienced body preoccupation or attempts to diet. Self-disclosure increased in **Phase II** as all members of the reflecting team began to share their own experiences on the continuum of eating behaviors. Secondly, joining the psychotherapy group seemed to allow the reflecting team to experience the group emotionally rather than be distant observers. For example, one reflecting team member expressed feeling similarly to the psychotherapy group. "I really noticed that it was kind of a somber tone to the group this week. Kind of low energy and I sort of felt that back there too (behind the one-way mirror). And I really appreciated the interaction that occurred within the group...it was actually a really hard thing for me to watch because I remember a time in group when I became very emotional." In **Phase II**, the psychotherapy group connected on an emotional level by sharing emotions rather than just talking about them. Similarly, the reflecting team shared in those emotions by experiencing them even with the protection of the mirror. Thirdly, the reflecting team's discussion within the larger circle became much less clinical or expert-like as the larger

group seemed to join together on one level. For example, one reflecting team member self disclosed, "And I always wanted to be able to change people, and of course, that's totally unrealistic to do that. And so in recovery I've just had to try and build my self-esteem and work on me and try to put less value on what other people say." Finally, the joining of the two groups seemed to allow a connection that became important to both the reflecting team and the psychotherapy group. Thus, supporting the psychotherapy group became an important job of the reflecting team. "I just wonder what that was like for people in the group to watch someone be vulnerable and what that was like to actually be vulnerable in a group and how that felt." Week 11, an emotional and courageous week where most members of the psychotherapy group were crying, became an equally emotional experience for the reflecting team members. "I found it really hard to watch because it tool me back to a time, this is very (crying) sorry. It took me back to a time when the eating disorder was stronger in my life and it made me really sad that there was such sadness. I sense some sort of desperation and I know what that feels like." Of course, if this is the experience of the reflecting team after they joined the psychotherapy group, then it is not surprising that a parallel process was taking place in the psychotherapy group. Self-disclosure, interaction, and the expression and processing of emotions increased in the psychotherapy group discussions in **Phase II**. A graphic representation of **Phase II** in Figure 2 provides a visual of how the safety level, factors in overcoming the eating disorder, and the psychotherapy group and reflecting team function together. Notice in the diagram that when safety was high, the focus of interaction was on action

strategies to overcome the eating disorder. Also, notice in **Phase II** that the reflecting team and the psychotherapy group have become one group encompassed by safety.

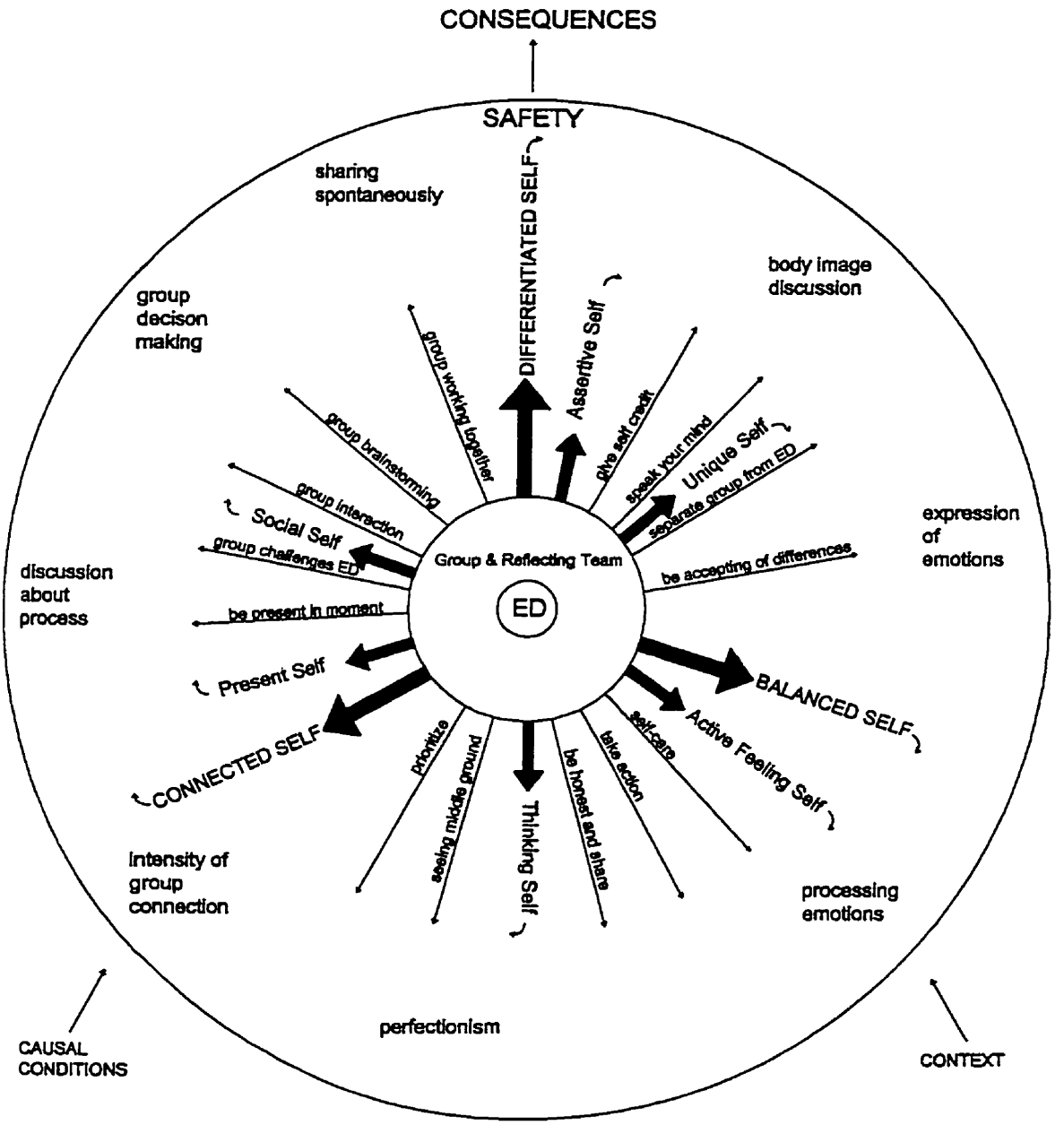
Making Connections to Safety Through The Paradigm Model

As detailed in Chapter Three, the paradigm model (Strauss & Corbin, 1990) is used to make connections between categories. The paradigm model including causal conditions, context, action strategies, intervening conditions and consequences was used throughout the coding process. The model that emerged from the data suggests that all categories are linked by the core category: safety of the group. The examples following use the paradigm model to illustrate the connection between major and minor categories. It helps us to understand how the model works in practice and provides an account of the movement of the group.

Causal conditions are the precipitating incidents that start a basic process. In **Phase I** the causal conditions are the influences of the eating disorder in life and relationships. In **Phase II** the causal conditions are important factors in overcoming eating disorders. The difference in causal conditions is determined by the safety of the group and thus starts the basic process. When safety is low the group talks about the eating disorder (familiar) and when safety is high the group talks about recovery (unfamiliar). One participant expressed this familiarity, "And it sort of, it's scary because it's (eating disorder) been with you for so long and you're not too sure how life will be like afterwards." The precipitating event is which topic the level of safety will allow to occur.

Figure 2

Phase II: Action Strategies to Overcome Eating Disorders



The context for both phases is the same. The context is defined as the set of conditions within which action strategies take place (Strauss & Corbin, 1990). In both phases the psychotherapy group functions within the context of a reflecting team and within the context of struggling with an eating disorder. One participant describes her experience with the eating disorder, "It's been good. It's been bad. It's been hell. It's been my best friend, and my enemy." The reflecting team and the eating disorder are present in both phases.

Strategies are defined as the manner in which a phenomenon is handled (Strauss & Corbin, 1990). Strategy implies action. In **Phase I** strategies to overcome the eating disorder were talked about somewhat but not practiced, however, in **Phase II** strategies were shared and experienced within the psychotherapy group. For example, in week 13 one member suggested they use brainstorming as an alternative to black and white thinking to come up with a group decision about what to do for the last session. "...[R]eally throw out their ideas, no judging and then go back and look at them." In general, the strategies were aimed at overcoming the influence of the eating disorder. For example, it seems logical to fight isolation with the **social self** strategies of **being with people who understand, breaking isolation** by coming to group, and **increasing social interaction**. Similarly, it makes sense that to conquer the **paralyzed self**, one might use the strategies of the **active feeling self** and **take action**.

Intervening conditions can facilitate or constrain the strategies taken. These conditions are the same throughout the 14 weeks. One constraint to taking action was the ambiguity members of the group expressed regarding change. "I've noticed in the last

little while I'm scared to let it (eating disorder) go because for me I think that I'm scared of who I really am inside." One condition that facilitates action is recognizing that things like recovery occur on a continuum. For example, recognizing that there will be setbacks to learn from, " I know I slip every now and again, but I'm starting to recognize the signs..."

Finally, what are the consequences of discussing the influence of the eating disorder? What are the consequences of hearing and practicing strategies to overcome the eating disorder? Again, the grounded theory emerging from this model points to the importance of safety. The consequence of discussing the eating disorder seems to be to build trust and safety in order to move to the **Phase II** where experiential learning can take place because safety has been established. For example, after one particularly challenging exercise, one group member was asked how she felt to have been honest with her emotions. She responded, "I feel powerful. I feel very determined. And I'm grateful for your encouragement." The paradigm model allows an overall view of the two phases of the group and illustrates how safety is the core category or basic social process that controls the movement between the two phases, the categories, sub-categories and properties. A visual representation of the overall process is represented in Figure 3.

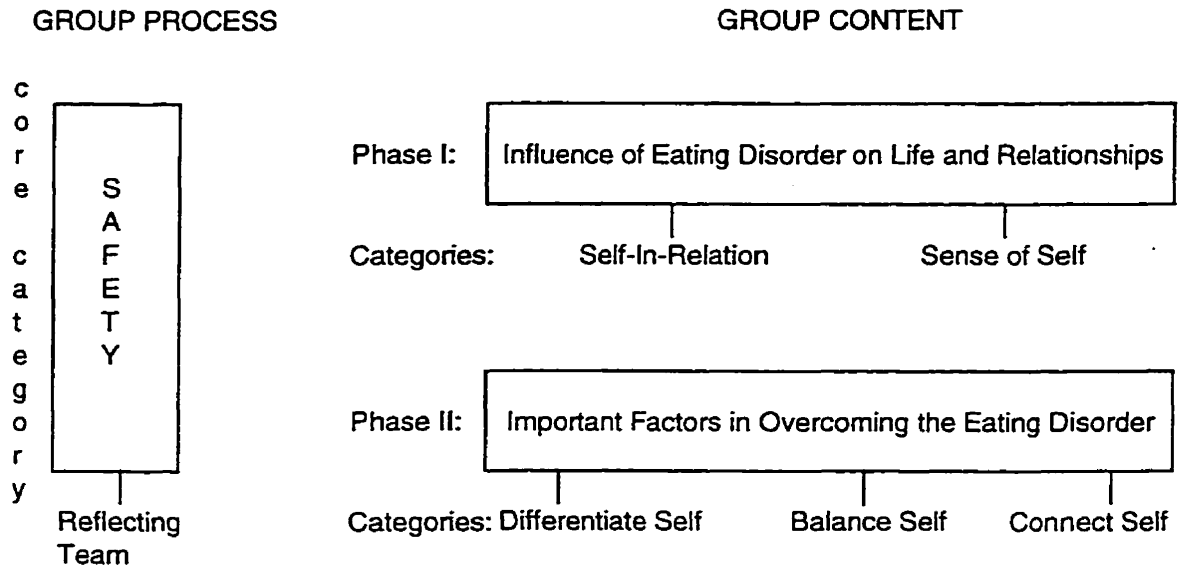
Summary

Chapter Four has demonstrated the grounded theory that resulted from the constant comparison of the interaction in the 14 weeks group psychotherapy therapy. First, ideas and themes from the perspective of the women in the group were uncovered to elucidate what they see as important to recovery. Secondly, the therapeutic contribution

of the reflecting team was uncovered and illustrated. Further, the core category of safety was discussed and illustrated in relation to two phases: the influence of the eating disorder on life and relationships and important factors in overcoming the eating disorder. Chapter Five takes the results of the analysis and relates it back to current literature on eating disorders and group interaction.

Figure 3

The Grounded Theory



CHAPTER FIVE: DISCUSSION

Chapter Overview

The purpose of this study was to explore how group therapy was useful for women with eating disorders. First, understanding the experiences of the women with eating disorders and secondly, exploring the contributions of the reflecting team, had potential to fill in the gaps in our understanding of group treatments for eating disorders. This chapter integrates the major findings of the study with relevant and existing literature in the field. Literature will be utilized in accordance with grounded theory methodology to validate the findings and place them in context with already existing literature. The first section presents a review of this study's major findings with the literature. This section details the findings of this study with literature on stages of group therapy and eating disorders. Specific attention is paid to the contribution of the reflecting team at each stage. Next, implications for counseling and recommendations for group therapy are presented. Finally, strengths and limitations of the study will be discussed as well as suggestions for future research.

Connections to the Literature on Eating Disorders

Group therapy has been considered by some to be the treatment of choice for women with eating disorders (Kettlewell et al., 1992; Kuba & Hanchey, 1991; Riess & Rutan, 1992). However, little conclusive research has been done regarding the therapeutic variables in group therapy for eating disorders that result in significant positive change (Kettlewell et al., 1992; McKisack & Waller, 1996). Additionally, research is lacking regarding the use of reflecting teams with an eating disorder psychotherapy group. The

findings of this project indicated that participants in group therapy for eating disorders pass through two phases and that the reflecting team played a pivotal role in the group's transition.

Corey and Corey (1987) theorize about the stages of group development in general and the developmental pattern of the psychotherapy group in this study offers support for their conceptualization. Corey and Corey describe the *initial stage* as a testing period where participants learn how the group is to operate and thus risk-taking is at a minimum. The central issue in the initial stage as described by these authors is trust versus mistrust. Although labeled **Phase I** in this study, these central characteristics describe the functioning of the eating disorder psychotherapy group for the first six sessions. In **Phase I**, the reflecting team seemed to be considered outsiders and the psychotherapy group seemed to find their presence somewhat odd and uncomfortable. The issue of control theorized in Chapter Two as an area for potential contribution by the reflecting team received some support in **Phase I** as the psychotherapy group eventually exercised their control and challenged their discomfort by inviting the reflecting team into their circle. Prior to this invitation, there was a period where the psychotherapy group questioned the usefulness of the reflecting team and seemed to protect against their influence. Initially, this mistrust seemed to hold the psychotherapy group back. It seemed then that one way this psychotherapy group managed their "mistrust" was first to question and then to invite the reflecting team into their circle.

The second stage in Corey and Corey's conceptualization of group development is the *transition stage*. Although not given a title in this project, the transition from **Phase I**

to **Phase II** was described as a two-part process. First, one group member confronted a group leader in session 7 about moving on from a topic too soon. Secondly, the reflecting team joined the psychotherapy circle rather than sitting separately for their reflection. Both of these actions eventually prompted a more cohesive group that was willing to take risks. Similarly, Corey and Corey (1987) describe conflict with the leaders as an indicator of the *transition stage*. Further, the leader functions described by Corey and Corey at the *transition stage* include to model dealing directly with challenges and to encourage the expression of emotional reactions in order to help the group move to an effective level of relating. It seems then that the reflecting team carried out both functions by directly joining the group to respond to their challenge and increasing connection with the group despite confrontation. The reflecting team seemed to take on some of the leaders' roles at the *transition phase*.

The reflecting team joining the psychotherapy circle offers some support for two potential contributions of the reflecting team described in Chapter Two. Isolation and healthy relationships were two themes about which the present researcher theorized the reflecting team could be beneficial. The joining of the two groups was a symbolic gesture that combatted the effects of isolation and created a larger social context within which the group functioned. Similarly, the opportunity for the psychotherapy group to develop a healthy relationship with the reflecting team was presented when the reflecting team decided to deal more directly with the psychotherapy group. This direct face–to-face style allowed the group to experience open communication. It seems then that especially at the

transition stage of the group development from **Phase I** to **Phase II**, that the reflecting team offered an additive component to the dynamics of group therapy.

The third stage described by Corey and Corey is the *working stage*. The working stage corresponds to **Phase II** in this study as risk-taking, support, and emotional expressions were present. At this phase, other hypotheses about the reflecting team's contribution were supported. The literature suggested that dichotomous thinking, perfectionism, and difficulty with emotional expression were characteristic of people with eating disorders. Again, theorizing suggests the possibility of the reflecting team being helpful in these areas. Throughout the group, the reflecting team modelled middle ground thinking by providing numerous alternatives and speculations about areas of content in the group. This consistent modeling may have contributed to the psychotherapy group's experiential learning as in **Phase II** they often brainstormed as a group to come up with their own alternatives. Further, the reflecting team often shared in the emotional experiences of the group and allowed their own emotional expression during their reflections. Again, some support for the contribution of the reflecting team was evidenced in **Phase II**.

Other researchers in the eating disorder area provide support for the findings of the two phases related temporally in this study; **Phase I: Influence of eating disorder on life and relationships** and **Phase II: Important Factors in overcoming the eating disorder**. Brotman, Alonso, and Herzog (1985) described a shift in their group treatment for eating disorders. As the group progressed, the focus shifted from eating behaviors to more interpersonal relationships. A similar conclusion was reached by Reed and Sech

(1985) in their experience working with groups of eating disorder clients. "In our group we came to believe that the real fear had nothing to do with fat, thin, or food. It was a fear of intimacy..." (p. 20). Likewise, Gendron, Lemberg, Allender and Bohanske (1992) described a process where members of the group reframed their eating disorder from a food problem into a interpersonal problem allowing the possibility of interpersonal solutions being effective. Group treatment offered special advantages because of the dynamics that can only come from real on-going relationships as the focus changes to developing a sense of self in relation to others.

Both existing group theory and eating disorder literature provide support for the findings of this study. Support for the contributions of the reflecting team was evidenced in both phases of this psychotherapy group. Control, isolation, healthy relationships, dichotomous thinking, perfectionism and difficulty with emotions were areas to which the reflecting team contributed. The findings offer some support that a reflecting team may contribute positively to group therapy for women with eating disorders.

Relevant Literature Support For The Major Categories

The findings from this study support aspects of the sociocultural, feminist, and relational models. Recall from Chapter Two that the sociocultural model included society and culture in the overall conceptualization of eating disorders. The feminist framework placed women in society on a continuum of eating behaviors where body preoccupation exists on the less extreme end and anorexia and bulimia toward the more extreme (Brown, 1993). Finally, the relational model of self-development (Gilligan, 1982) brought forth the importance of females developing their sense of self in relation to other people.

These three theories will be explored again in relation to the major categories derived from this study.

Self-In-Relation and Sense of Self

Surrey's (1991b) self-in-relation model proposes that an autonomous self can be developed within healthy relationships and that in fact this is how female development occurs.

Gilligan (1982) suggests that the notion of "self" does not fit women's experience. Increased separation and self-development characterize many early models of development and neglect the notion that others may play a role in the formation of a sense of self (Surrey, 1991a). The findings of the present study indicate the importance of developing a **SELF-IN-RELATION** but emphasizes equally the importance of a **SENSE OF SELF** that does not **only give to others**. The possibility that a large portion of women's sense of self may revolve around the inclusion of others is not being disputed, as long as it is not to the exclusion of self-experience. Ideally, the two categories work together as Kaplan (1982) describes, the self is enhanced through relationships with others.

Literature on eating disorders also suggests that the two concepts of **SELF-IN-RELATION** and **SENSE OF SELF** intertwine. Hall (1985) describes clients with eating disorders as limited in their ability to form and benefit from meaningful relationships and relate this difficulty to poor self-esteem. King (1994) describes the experiences of women with eating disorders as an exaggerated picture of a common dilemma. These women try to balance: a) the values of achievement with a self-concept defined in terms of

traditional females values (like physical appearance) and b) a sense of self that integrates self-identity with relationships to others. Other authors have found that both the **SENSE OF SELF** and **SELF-IN-RELATION** play a role with women with eating disorders. For example, Roth and Ross (1988) focused on both the interpersonal and self-referential beliefs of the members in their study of long-term group therapy for eating disorders. Steiner-Adair (1986) conceptualizes eating disorders within a larger context by looking at the larger message women with eating disorders are sending. The emaciated female becomes a symbol of a society that does not value the relationships that are essential to female development. The message speaks loudly about a culture that values independence over inter-relatedness. It seems then that **SELF-IN-RELATION** and **SENSE OF SELF** are integrally connected and fundamental constructs in the treatment of eating disorders.

Differentiated or Connected: The Balanced Self

Similar literature can be used to support the three major themes uncovered in **Phase II** of the psychotherapy group. Romney (1995) describes anorexia and bulimia as "manifestations of both the striving for individuality and longing for connection" (p.53). Romney claims that her recognition of these two compatible needs has informed her counseling practice. "It is up to each person to find the healthy balance that works for her, and treatment should support that search" (p.56). There is anecdotal evidence for the importance of both autonomy (Frederick & Grow, 1996) and connection (Laube, 1990) in the etiology and treatment of eating disorders. Laube (1990) suggests that because the group is a living social system, it provides a parallel process for the being of each participant in group. In other words, as a member develops connections in the group

dynamics, her **DIFFERENTIATED** self is also developing. Kaplan (1982) also suggests that a balance is achieved in optimal women's development between connection and differentiation, "Connection with others, then, is a key component of action and growth, not a detraction from or a means to one's self-enhancement..." (p.208).

The feminist model takes the self-in-relation theory one step further and suggests that society's lack of valuing of relationships and connectedness is a barrier for women to develop a healthy sense of self in relation (Kaplan, 1982; Lazerson, 1992). Results from this study also suggest that overcoming societal messages is an important part of addressing an eating disorder. Friedman (1993) suggests that the systematic devaluation of what is important to women's development influences how women define themselves and how they interact with others. Kuba and Hanchey (1991) suggest that group treatment is found to be most helpful in integrating a feminist perspective because it allows women to develop their sense of self in relationship to others. These authors describe group therapy for eating disorders as "...the ongoing process of merger and separation which vascillate until stabilization of the self" (p.132). Thus, understanding the oppression of women and utilizing the strength of women in connection through group therapy facilitates the development of self.

Implications For Counseling Practice

Results from this study provide support for existing literature in the area of eating disorders. In addition, a number of suggestions about improving the quality of treatments for women with eating disorders result from listening to the voices of women who suffer.

Safety Considerations

Results from this study indicate that safety was the core category or the basic social process being studied. The importance of this category indicates that more attention may be needed in the area of the perceived safety of group therapy for eating disorders. Most current literature on group treatment for eating disorders mentions safety or trust as the first stage of group development but little emphasis is placed on its importance (Rosenvinge, 1990; Srebnik & Saltzberg, 1994). The fundamental nature of safety in this psychotherapy group suggests that counselors may want to re-consider how eating disorder groups evolve. Establishing safety may be a necessary phase and counselors may want to be cognizant of the importance of established safety for the therapeutic process.

One area that may inform practice in this regard is the literature on sexual abuse. Because abuse violates a basic sense of trust, establishing safety is the primary goal throughout work with clients (Dolan, 1991). In fact, techniques are not recommended with clients who have experienced sexual abuse until a strong therapeutic relationship has been established (Kearney-Cooke & Striegel-Moore, 1994). Borrowing from the sexual abuse literature does not imply that this study's results warrant entering into the debate about the connection between sexual abuse and eating disorders. Rather, the sexual abuse literature has potential to inform about safety issues in eating disorder group work. The literature on sexual abuse may help illuminate how group counselors can best facilitate an environment where trust can be established in both self and others.

Establishing Common Ground

One way to establish safety in this psychotherapy group seemed to be to find the similarities in participants' experience. This factor is often referred to as *universality* or the sharing of common experiences (Jones & Stone, 1992). Other researchers have found this feature of group therapy important. "Our clients uniformly report that the most important feature for each is the personal contact with other victims and the experience of sharing...with others who 'really know what it's about'" (Lenihan & Sanders, 1984, p. 254). Learning that one is not alone in the struggle can be empowering and encourage the group to move forward.

The use of metaphors. One of the ways the participants established common ground was through the use of metaphors. Results of this study indicated that this group used powerful metaphors to describe the eating disorder to other members. This disclosure of the misery of having an eating disorder seemed to help reduce the isolation. A number of metaphors were used by participants especially in **Phase I** . One member described her eating disorder as a radio station: "...[I]n my head, it's a radio station and you're in the middle of the two, that big static." Another member connected to this description immediately after except in a visual way: "It's like a fog and you can't see clearly." Another described her eating disorder as an experience of being chased: "...[S]lip back into the forces of some big black snake which is 2 feet behind me. I sort of feel like I'm being chased by it." Another member also felt like it was behind her but described it as a shadow: " ...[I]s it always going to be like a shadow and I'm always looking over my shoulder at the shadow and just trying to stay two steps ahead of it?" Another member described her eating disorder as lying and manipulative: "My experience

is that (the eating disorder is this) horrible salesman that says wrinkle cream will make you beautiful..." Another client talked directly to her eating disorder to describe it like a pimp and a Mafia godfather: "You must have reveled in your success - another unsuspecting female lured into your world of prostitution and I despise you for that...you are somewhat akin to a godfather in the Mafia, only you do worse than kill and torture your victims. How cold and cruel you are." The eating disorder was also likened to an abusive relationship: "In my mind I sort of see the eating disorder as being an abusive partner and that I'm – the healthy part of me is being abused by this person..." Another member saw the eating disorder as more fragile: "...[I]t's like this little bubble and I live in my own little world and nobody touches me, so I'm kind of floating around..." It seemed then that even though the metaphors used to describe the eating disorder were diverse, that the disclosure of how the eating disorder was experienced allowed a sense of being understood.

The therapeutic value of the metaphor has been explored primarily in the literature from the narrative perspective (Zimmerman & Dickerson, 1994). According to these authors, the narrative metaphor is useful because people organize their life experiences in the form of stories. Lowe (1990) speculates that the metaphor brings forth ideas that can help people live with some measure of understanding. Specifically for women with eating disorders, the use of metaphor can provide opportunities for women to look at the implications of the eating disorder on their lives and the implications of the continuum of eating behaviors on women in general. Epston, Morris and Maisel (1995) suggest the metaphors can be useful for women with eating disorders:

> Metaphorical descriptions, (e.g., "the concentration camp of anorexia/bulimia," "living death," "being on death row," etc.) can help persons "unmask" or see through the ways anorexia/bulimia operates on people's lives, inviting associations which can enliven and enrich these descriptions. Persons can be invited to assess the extent to which such descriptions match or capture their experience of anorexia/bulimia in their lives. (p. 73)

Essentially, the metaphors that were shared by the psychotherapy group members allowed for exploration of the similarities and differences in their experience and provided an avenue for finding common ground.

Exploring Body Image

The psychotherapy group also found common ground around the subject of body image. However, unlike the use of metaphors, the reaction to the proposed body image discussion was a negative reaction. In fact, the safety of the psychotherapy group was damaged when a body image exercise was proposed in session 2. In retrospect, giving the emotional quality associated with body image, this exercise was premature and more of a challenge than the safety of a new group could manage. Given that for women with eating disorders, the evaluation of self may be solely based upon the perception of the body (Hesse-Biber, 1996; Pipher, 1995), it is not surprising that the group considered this exercise a threat. The eating disorder literature offers support for the suggestion that discussion about body image should come later in the group interaction. For example, in a successful short –term group therapy, Jones and Stone (1992) structured their group so that body image was the second last topic in a fourteen session group. As suggested in

Chapter Two, the emergence of the "real self" must take place in a safe environment when alternatives to the eating disorder identity have been explored.

Srebnik and Saltzberg (1994) suggest the group interaction center on understanding fears and concerns around body image issues before attempting change. Feminist researchers would criticize the attempt at a body image exercise in this study given that the context of a "normative discontent" was not yet established (Rodin et al., 1985). Body image concerns were not placed within the larger sociocultural context by discussing the influence of cultural messages on women and women's normal development. Counselors may want to consider approaching body image when safety and trust is clearly established and when alternate identities have been discussed. Further, when discussing body image, normalizing concerns by placing the issue within our larger society is good practice (Srebnik & Saltzberg, 1994).

Experiencing Affect

One of the most powerful experiences in this psychotherapy group was the emotional expression that resulted from the empty chair technique. Each member of the group, in turn, was asked to a) talk to the eating disorder (the empty chair) about what it has been like to have it in her life, b) switch chairs, become the eating disorder and talk to self about what it has been like to have power and influence, and c) switch chairs again and talk to the eating disorder about the ways in which she already exercises power and influence over it. This exercise was incredibly powerful and emotional and all members of the group including the reflecting team expressed emotion through tears. This sharing

and processing of emotions seemed to provide a depth of connection that allowed for group and individual development.

The eating disorder literature provides support for the importance of experiencing emotions in group therapy (Baumann, 1992). People with eating disorders have been characterized as deficit in the area of recognizing, articulating and expressing emotion (Brouwers, 1991; Kuba & Hanchey, 1991). In fact, Barth (1994) views symptoms of eating disorders as responses to unprocessed emotions. Barth (1994) and Baumann (1992) suggest that group therapy offers an avenue for the development of the skills necessary to experience feelings. For example, group members can identify in others what they cannot experience themselves (Barth, 1994). The group experience can be a safe and supportive environment to reflect, name, and accept new feelings. Barth describes this process:

> Thus, in the group setting, an individual can learn to articulate and manage her feelings first, and eventually to understand their meanings, through repeated and ongoing experiences of having the feelings responded to, named and affirmed from within her own perspective – an experience that is a basic and necessary component in the development of a subjective sense of who one is and what one feels and thinks – in short, a sense of self. (p.76-77).

This is an excellent example of the self-in-relation theory in action with the expression of emotions in the group interaction.

Working with Cognition

The cognitive component of the group member's experience was apparent throughout the group. Members often expressed the "two voices" that play or describe the "negative thinking" that takes over. Unlike actual emotional expression that was an important feature of **Phase II**, cognition was an important topic of discussion throughout the entire psychotherapy group. Literature supports the notion of cognitive distortion playing a role in the maintenance of eating disorders. A number of labels have been used in the literature to describe these thoughts: distorted expectations, perfectionistic thinking, all-or-nothing reasoning, overgeneralization, rigid thinking, automatic thoughts, black and white thinking, and dysfunctional self-talk (e.g., Jones & Stone, 1992; Srebnik & Saltzberg, 1994; Thorton & DeBlassie, 1989; Zotter & Crowther, 1991).

It is not surprising then that some of the most promising treatment programs reported to date involve a cognitive component to the treatment (Romano, Quinn, & Halmi, 1992; Srebnik & Saltzberg, 1994; Thorton & DeBlassie, 1989). Feminist researchers criticize traditional cognitive-behavioral treatments for continuing to oppress women that are trying through their eating disorder to resist oppression (Srebnik & Saltzberg, 1994). An integration of feminist therapy with cognitive therapy may alleviate this oppression. Identifying, normalizing and re-labeling of negative thoughts can be done in a similar manner to traditional cognitive restructuring. However, this technique must be balanced by the inclusion of the larger sociocultural context and the realization it is not an individual problem (Srebnik & Saltzberg, 1994). Thus, eating disorder research and this study support the use of cognitive therapy as one aspect of treatment, however,

traditional techniques need to be modified to account for the experience of women in the larger culture.

Behavioral Strategies of Treatment

Practicing behaviors and taking action to combat the eating disorder are equally as important to treatment as experiencing affect and working with cognition.

Action strategies. The shift from talking about the eating disorder to talking about overcoming it, seemed an important step in the development of the group. Once the group had established a level of safety and explored their commonalities through the use of metaphor, focus shifted from the eating disorder to a search for self. The focus on *how* seemed to spur the group into action.

Rehearsal and corrective experiences. Actual practice of some of the strategies seemed particularly helpful to the group members. Participants shifted from only discussing, to taking the opportunities that the psychotherapy group offered to experience. For example, instead of just talking about the **assertive self**, group members were allowed the opportunity to be assertive and to express their needs. The level of insight and understanding seemed to move from a purely cognitive level which seemed to intellectualize, to actually experiencing in the here and now. For example, talking about negative thinking and the **thinking self** was important but it seemed to have more impact when the eating disorder was actually challenged in the group. For example, one member of the psychotherapy group directly challenged another member.

> " ...I was shaking my head for a minute when you were talking because it's just so incredibly evident how the eating disorder was talking through you for few

> minutes - it was so negative and I got really angry all of a sudden. I wanted to come over there and just take it and clobber it because it was – you were talking so negatively about yourself – it made me angry for a few minutes and then it made me sad because I don't see that in you – I see good things in you."

This is a powerful example of what Barth (1994) considers as the ability to see in others what you cannot see in yourself. Again, the experiential component was powerful because it provided the psychotherapy group with opportunities to create aspects of self in a group setting. Some authors imply that the experiential component is a necessary part of recovery in group therapy with eating disorders (Gendron et al., 1992; Kuba &Hanchey, 1991; Laube, 1990). Counselors may want to consider setting up opportunities for their clients to experience and practice aspects of self in a safe group setting.

Summary

As indicated from this research project, affect, thought, and behavior are important aspects of treatment and all need to be attended to in a treatment program for eating disorders. Results from this study also indicate that safety is of specific importance to the functioning of a psychotherapy group for eating disorders and may require more attention than it is currently being given. Negative body image is generally considered a hallmark symptom of eating disorders, however, results indicate that this topic needs to be approached in an appropriate and timely manner. Overall, group treatment seems to provide a unique opportunity to experience and practice **SELF-IN-RELATION** and by doing so, gain a **SENSE OF SELF** that is **CONNECTED, BALANCED**, and **DIFFERENTIATED.**

Strengths and Limitations of the Current Study

This study is one of the few studies that attempts to account for the experiences of the women with eating disorders. By listening and validating the voices of the people who struggle with eating disorders, some of our current understandings of eating disorders are supported and enhanced. Quantitative understandings of eating disorders provide the ability to test, diagnose, and characterize but give us little information about the actual experience of struggling with an eating disorder. Similarly, quantitative studies can determine that group therapy is useful but provide little information about how or why it is effective. This study began to bridge some of the gaps in our understanding of eating disorders and the women who experience them.

Because reflecting teams have never before been studied with group psychotherapy for eating disorders, this study was exploratory in nature. The reflecting team mirrored back to the psychotherapy group the content and process of the interaction. The findings of this study indicate that the reflecting team was additive to the group experience especially around the transition phase and the issue of safety. For example, the reflecting team may have been able to challenge and confront the psychotherapy group when the fragile safety in the room would not allow the facilitators to take on that role. The reflecting team becomes symbolic in their use with an eating disorder group because the team reflects back a sense of self in relation that the women in the group are searching for. Essentially, the reflecting team offered a different interpretation of what the group saw as they looked in the mirror.

The limitations of this study are in large part in reference to issues of methodology. However, what some researchers may consider limitations, others may consider strengths. Issues that could be considered both strengths and limitations are the role of the researcher, theoretical sampling, and the exploratory nature of the study. Likely more agreeable as limitations are the lack of follow up with psychotherapy group members and lack of application of other data collection methods.

A possible limitation of the study was the role of the researcher in both co-facilitating the psychotherapy group and extrapolating themes. The researcher who has herself recovered from an eating disorder may have attended to only certain information in the analysis process. It may have been beneficial, with access to resources, to include the other co-facilitator as co-researcher to independently analyze the data. Differences or lack of difference in the analysis would have helped to control for the current researcher's experience of recovery.

A possible strength of the study was the role of the researcher given her own experience with eating disorders. Perhaps because the interpreter of the information has personal experience with the issue being studied, the resulting grounded theory remains true to the voices of the women who have struggled. To prevent my experience from becoming a liability in this study, my personal reactions and reflections about the group were tracked throughout data collection and analysis.

Ideally, data collection and analysis occur simultaneously in grounded theory. However, analysis in this study did not begin until all fourteen weeks of group were complete. The decision to postpone analysis was based upon the specific circumstances in

this study. Because the researcher was also co-facilitator, strict adherence to grounded theory procedures may have unduly influenced the group interaction. By separating these two roles temporally, it was hoped that researcher influence would be limited. Therefore, a decision was made that it was more important to limit researcher influence and thus analysis did not begin until the completion of the psychotherapy group.

This study was one of a limited number of studies that attempted to uncover how group therapy is effective for women with eating disorders. Further, even fewer studies have researched the experiences of the women participants to determine their perspective on the value of group therapy. Thus, this study was exploratory in nature and based upon an in-depth understanding of 6 female members of an eating disorder psychotherapy group. Thus, this study's conclusions cannot be transferred beyond these participants.

Given that the interview is considered a process of negotiation of meaning between the researcher and participants, follow-up with group members would have increased the credibility of this study. However, given that the data was collected in a group setting, some of this negotiation occurs as part of the group interaction. Future research with group therapy for eating disordered women should include a follow-up with the women to be sure the theory uncovered from the data accurately reflects their experiences.

Dependability of this study may have been enhanced by applying other data collection methods such as journals or individual interviews with both the psychotherapy group and the reflecting team. Those who conduct future studies using grounded theory

with group therapy may want to employ such collection methods to enhance the dependability of their findings.

Suggestions for Future Research

The findings from this study are a starting point for future research that incorporates the voices of women who experience eating disorders. The model generated may help guide our understanding of the common themes that women with eating disorders perceive as important to recovery. Suggestions for future research revolve around validating and testing this model to determine its usefulness and application to other modalities of treatments for eating disorders.

An evaluation of the effectiveness of group psychotherapy for eating disorders using this model would provide information about the practicality of this study's suggestions. Validating the themes with other women with eating disorders in other settings like individual or couple counseling and with other psychotherapy groups would also be useful. A comparative grounded theory study may also be beneficial in identifying differences between women struggling with anorexia versus women struggling with bulimia. Essentially, testing this model with other women in diverse settings could lead to a richer description of the variables that women with eating disorders see as important to recovery.

Further, to place this model within the context of our larger society, it would be important to test this model on women on the lower end of the continuum of eating behaviors. Exploring how this model fits for women that do not have eating disorders per se, but may experience body preoccupation or yo-yo dieting may be enlightening. In

addition, it is also important to include the experience of women from more diverse class and ethnic backgrounds so that similarities and differences in their experience of the recovery process can be accounted for. Finally, since the methodology is a work in progress, the grounded theory may be modified and revised as more information is incorporated. Thus, further studies based on similar methods are needed to support this model.

Summary

The purpose of this study was to explore the interaction of group with special attention to the voices and experiences of the women who experience eating disorders. Of particular interest was the influence of the reflecting team on group therapy. Grounded theory methodology (Strauss & Corbin, 1990) was chosen by the researcher because there was some degree of fit between grounded theory and feminism. For example, grounded theory can be set up to remain true to the voices of the participants.

The interpretation of results uncovered the core category of **safety**. The psychotherapy group moved from **Phase I: influence of eating disorder on life and relationships** to **Phase II: important factors in overcoming the eating disorder** based on the level of safety in the group. In both phases of the group, developing a sense of self in relation to others was paramount to the recovery process. As the group developed, it became apparent that the eating disorder was really secondary to a lack of sense of self and overcoming the eating disorder was about developing a sense of self while in relationships with other people.

Support for the use of reflecting teams in group therapy for eating disorders was uncovered from the data. The reflecting team seemed particularly important around the transition phase of this group as it became a vehicle for the group to establish safety. Further, the addition of the reflecting team allowed processing of a number of issues like control, healthy relationships, isolation, dichotomous thinking, perfectionism, and difficulty with emotion.

The grounded theory that emerged was related back to literature on eating disorders and female development, and group therapy. Finally, the grounded theory also resulted in recommendations to counselors in group settings in order to better serve women with eating disorders.

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THE UNIVERSITY OF
CALGARY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

LETTER OF INFORMATION

Dear _____:

My name is Michelle Russell. I am a graduate student in the Department of Educational Psychology at the University of Calgary, conducting a research project under the supervision of Dr. Nancy Arthur, as part of the requirements towards a M.Sc. degree. I am writing to provide information regarding my research project **Group Themes: Reflections from Group Therapy for Eating Disorders** so that you can make an informed decision regarding your participation.

The purpose of this study is to investigate the process of group counseling for people struggling with an eating disorder. As part of the study you will be asked to allow me to videotape the sessions and view the videotapes to review relevant themes and progress as a group. The verbal content of the videos will be transcribed (eliminating any identifying information) and the transcripts will be reviewed by three researchers; myself, one other group facilitator, and my supervisor, Nancy Arthur.

Participation in group therapy may involve disclosing personal issues and hearing other people's issues not normally talked about in every day life. In turn, participants of group therapy may find it beneficial to learn from the experiences of others. Participation in this study will involve no greater risks than your participation in this group. Further, your decision to participate will in no way affect your participation in the psychotherapy group. You should be aware that even if you give permission you are free to withdraw at any time for any reason and without penalty.

Data will be gathered in such a way as to ensure anonymity. Any identifying information will be changed to maintain confidentiality. Your name or any identifying information will not be released during or after the study. In other words, no personally identifying information will be placed on the transcripts.

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4
Telephone: (403) 220-5651 Fax: (403) 282-9244

THE UNIVERSITY OF
CALGARY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

None of the data will be reviewed until after the completion of the group. That way, there will be no confusion between the group psychotherapy experience and participation in this study. Once collected, videos will be kept in strictest confidence in a locked room at the Calgary Counseling Centre. The videos will be erased after seven years by a mechanical erasing machine. Transcribed verbal content will be kept in a locked cabinet by the three above mentioned researchers, only to be removed for review. The transcripts, without identifying information, will be kept for five years, after which they will be destroyed by shredding.

If you have any questions, please feel free to contact me at 228-5275, my supervisor, Dr. Nancy Arthur at 220-6756, the Office of the Chair, Faculty of Education Joint Ethics Committee at 220-5626 or the Office of the Vice-President (Research) at 220-3381. Two copies of the consent form are provided. Please return one signed copy to me and retain the other copy for your records.
Thank you for considering participation in this research study.

Sincerely,

_____

Michelle (Shelly) Russell, B.Sc. (Hons.)
M.Sc. student

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4
Telephone: (403) 220-5651 Fax: (403) 282-9244

THE UNIVERSITY OF
CALGARY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

CONSENT FOR RESEARCH PARTICIPATION

I, the undersigned, hereby give my consent to participate in a University of Calgary research project entitled **Group Themes: Reflections from Group Therapy for Eating Disorders**

I understand that such consent means that I will take part in allowing the present researcher to videotape the sessions and review the videotapes of the 14 group sessions. I understand that the verbal content of the videos will be transcribed and any identifying information removed (i.e. Fictitious names used). Transcripts will be reviewed by three researchers, the present researcher, Michelle Russell, one other group facilitator, and Nancy Arthur, the supervisor of this research project.

I understand that participation in this study may be terminated at any time by my request. I understand that if I withdraw all verbal content specific to me will be removed from the transcripts. Participating in this project and/or withdrawal from this project will not adversely affect me in any way. Further, it will not effect my membership in the psychotherapy group in any way.

I understand that participation in group therapy may involve disclosing personal issues and hearing other people's issues not normally talked about in every day life. I also understand that some participants of group therapy may find it beneficial to learn from the experiences of others. Further, I understand that this study will not involve any greater risks than my participation in the psychotherapy group.

I understand that every effort will be taken to safeguard my privacy and that any identifying information will be changed to maintain confidentiality.

I understand that the videotapes are kept in a locked room at the Calgary Counseling Center and transcripts will be kept in a locked drawer by the three above mentioned researchers and removed only when reviewed. The transcripts, without identifying information, will be kept for five years, after which they will be destroyed by shredding. The videotapes will be erased by a machine after seven years.

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4
Telephone: (403) 220-5651 Fax: (403) 282-9244

THE UNIVERSITY OF
CALGARY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

I have received a copy of this consent form for my records, I understand that if I have any questions I can contact the researcher at 228-5275, my supervisor at 220-6756, the Office of the Chair, Faculty of Education Joint Ethics Committee at 220-5626, or the Office of the Vice-President (Research) 220-3381.

_____

Date Signature

_____

Participant's Printed Name

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4
Telephone: (403) 220-5651 Fax: (403) 282-9244

THE PASTORAL INSTITUTE
PROFESSIONAL COUNSELLING SERVICES IN THE COMMUNITY

SUITE 200,
940 - 6 AVENUE S.W.
CALGARY, ALBERTA
CANADA T2P 3T1

Dear Colleague:

Our clients are required to complete a medical examination before starting our treatment program. Your input is greatly needed to insure a high level of care for our clients.

All of our clients must have lab work done and a copy forwarded to our office at The Pastoral Institute. You may use a lab of your choice.

We would appreciate your help in filling out this medical form and returning it to us in the self-addressed stamped envelope as soon as possible in order to facilitate our treatment planning. Thank you for your cooperation.

Sincerely,

Counsellor
Eating Disorder Program

Enclosure

REF:960426RBW.001

Funds Provided By:
United Way of Calgary and area
THE CALGARY FOUNDATION
Wild Rose Foundation

THE PASTORAL INSTITUTE
PROFESSIONAL COUNSELLING SERVICES IN THE COMMUNITY

SUITE 200,
940 - 6 AVENUE S.W.
CALGARY, ALBERTA
CANADA T2P 3T1

The Pastoral Institute
Eating Disorder Program

POLICY STATEMENT
MEDICAL STABILITY

In order to provide comprehensive treatment of eating disorders, we must be assured of the relative medical stability of our clients. This particularly applies to bulimic and/or anorexic clients who may be experiencing severe medical symptoms. If a client has been determined to be at medical risk, it is a requirement of entry into treatment and a condition of remaining in treatment, that the client's physician establish a collaborative relationship with our staff. We will require the physician to create and implement a medical treatment plan for the client and the client must comply or be discharged from treatment.

If you or your family members believe at any time that you are experiencing a medical emergency due to your eating disorder behaviour, then it is important to go to the emergency room of the hospital where your physician has admitting privileges. Please get that information from your doctor and be sure that your family and we at The Pastoral Institute know to which hospital you should go.

My signature indicates that I have read and understood the above policy statement.

CLIENT NAME _____ DATE _____

COUNSELLOR SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

REF:960426RBW.002

THE PASTORAL INSTITUTE

EATING DISORDER PROGRAM

OFFICE USE ONLY

Pastoral Institute
Counsellor:_____
(403)265-4980

Med.Rec._____
Date

Lab.Rec._____
Date

MEDICAL EXAMINATION

Date:_____

PATIENT'S NAME:_____

AGE: _____
ADDRESS: _____
_____

MARITAL STATUS:_____

G____ P____ TA___ SA___

PHYSICAL EXAM:

Ht:_____ Wt:_____ Pulse:_____ B/P:_____
Temp:_____

HEENT:_____
_____
_____

HEART:_____
_____
_____

LUNGS:_____
_____
_____

ABDOMEN:_____
_____
_____

EXTREMITIES:_____

PAST MEDICAL HISTORY:

SURGERY:_____

_____

_____

SIGNIFICANT ILLNESSES:_____

_____

_____

MENSTRUAL HISTORY: Menarche - _____

Cycle - _____

LNMP - _____

REVIEW OF SYSTEMS:

MEDICATION (Please indicate all current medications/dosages exactly as prescribed; also indicate reason for this medication):_____

_____

_____

_____

ALLERGIES: a) Medications:_____

_____

b) Foods:_____

_____

PERTINENT FAMILY HISTORY:

_____

_____

_____

CURRENT BEHAVIOUR PATTERNS:

OCCUPATION:_____

SMOKER:_____

HOW MUCH ALCOHOL OR RECREATIONAL DRUGS (if any) USED DAILY:_____

_____

_____

TO YOUR KNOWLEDGE, IS THIS PERSON PURGING BY:

		Yes	No	Has in Past
a.	vomiting	_____	_____	_____
b.	laxatives	_____	_____	_____
c.	diuretics	_____	_____	_____
d.	restrictive dieting	_____	_____	_____
e.	excessive exercise	_____	_____	_____

LABORATORY TESTS:

Please order the following lab test:

TSH	CBC	Electrolyte	BUN
Creatinine	Albumin	Total Protein	Calcium
Phosphate	Magnesium	Total Bilirubin	PT

Forward results to The Pastoral Institute, along with this form.

EKG (optional):_____
CHEST X-RAY (optional):_____
OTHER LAB (optional):_____
PREGNANCY TEST (if so indicated):_____

PHYSICIAN RECOMMENDATIONS:

1. In your opinion, should this person have any special foods or food schedule because of health reasons?
   Yes_____ No_____ (If yes, please explain)
   _____
   _____
   _____

2. Does this person have current medical problems related to weight?
   Yes_____ No_____ (If yes, please explain)
   _____
   _____
   _____

3. To your knowledge, has this person attempted healthy weight reduction in the past?
   Yes_____ No_____ (If yes, please explain)
   _____
   _____
   _____

4. In your opinion, should this person restrict or modify his/her consumption of the following due to medical problems:

		Yes	No
a.	Salt	_____	_____
b.	refined sugars	_____	_____
c.	cholesterol	_____	_____
d.	alcohol	_____	_____
e.	caffeine	_____	_____

5. In your opinion, are there any medical reasons to prohibit this patient from participating in a program of physical exercise?
Yes_____ No_____ (If yes, please explain)

_____
_____
_____

6. Please describe, in summary form, any medical conditions that are related to, or the result of, the patient's eating disorder:

_____
_____
_____

7. In order to provide continuity of care, are there any other medical concerns that The Pastoral Institute staff should be aware of or to be alerted to?

_____
_____
_____

8. Is medical follow-up indicated for this patient?
Yes_____ No_____ (If yes, please explain)

_____
_____
_____

9. Is there history of family violence or sexual abuse?
Yes_____ No_____

Name:_____
(please print)
Signature:_____
Date:_____

Please type or stamp name and address of physician should follow-up be necessary.
REF:FORMS\EAT.DIS\0496

The Pastoral Institute

CONSENT FORM

I agree to participate in a research project whose purpose is to evaluate the effectiveness of the counselling program and services of The Pastoral Institute. The research project is being conducted by staff from The Pastoral Institute.

The research coincides with The Pastoral Institute's ongoing efforts to evaluate the effectiveness of their programs. The research has the additional aim of circulating the results of the evaluation through publication in professional journals. This is to ensure that other professionals may learn from the research endeavour. All consumers who participate in the research will be provided, upon request, with a copy of any publications that result from the research.

I understand that my participation in the research project may involve completing a number of questionnaires at various points over the course of my counselling or group involvement and at two or three points following the completion of counselling and/or group (e.g. at 6 months and 1 year after the group ends).

I understand that all responses will be kept completely confidential and that information which could identify any clients will not be used. I also understand that I may withdraw from the research project at any time without affecting my participation in The Pastoral Institute's programs.

Signature of Participant: _____

Date: _____

Signature of Witness: _____

Date: _____

JAN 1994
REF:WP51\ROBBIE\RESEARCH.CONSENT

Suite 200, 940 - 6 Avenue S.W., Calgary, Alberta, Canada T2P 3T1
Phone (403) 265-4960 Fax (403) 265-6886

THE PASTORAL INSTITUTE
CONSENT FOR AUDIO-VISUAL RECORDING

Confidentiality

It is important to The Pastoral Institute that consumers understand that all information regarding your participation at The Pastoral Institute is kept confidential. Even within the agency information is only shared with those professionals (e.g. supervisors, interns and residents) who will confer with your counsellor/facilitator and thereby enhance the services you receive.

Consent for Audio and/or Video Taping

I/We _____ authorize The Pastoral Institute to record on audio or videotape our interviews and to use the same to facilitate their work with us (and our families) and for professional education purposes within the agency.

I/We voluntarily authorize the use of a tape for:

a)	Review by my/our Counsellor and his/her supervisor/consultant.	[ ] Yes	[ ] No
b)	Education of interns and clinical staff within The Pastoral Institute	[ ] Yes	[ ] No
c)	Education of Professionals external to The Pastoral Institute	[ ] Yes	[ ] No

I reserve the right to have any or all of the recordings erased on delivery of written notice to The Pastoral Institute.

_____

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR AUDIO AND/OR VIDEOTAPING RECORDING AND DO SO CONSENT.

Signature(s): _____ _____

_____ _____

Date: _____, 19__

Counsellor: _____

(A copy of this signed document is to be given to the client)

REF:FORMS\AUDIO.CON

Calgary Counselling Centre
Formerly The Pastoral Institute
Suite 200, 940 - 6 Avenue S.W., Calgary, Alberta, Canada T2P 3T1
Telephone (403) 265-4980 Facsimile (403) 265-8886

January 7, 1997

To Whom It May Concern:

I, Robbie Babins-Wagner, Executive Director of the Calgary Counselling Centre, agree to Ms. Michelle (Shelly) Russell's participation as a volunteer co-facilitator in the eating disorder psychotherapy group. Further, I have read Ms. Russell's proposal for her research entitled **The Process of Healing: Reflections from Group Therapy for Eating Disorders** and agree to allow her to collect data at this agency for purposes of this research.

Ethically, the agency is responsible for the safety of the clients in group therapy and will be following agency policy regarding safety issues. Further, we are responsible for the informed consent in regards to videotaping sessions and the resulting video tapes are the property of the Calgary Counselling Centre. As such, agency policy will be followed, as usual, regarding the ethical responsibilities to our clients and their files. I understand that Ms. Russell will add consent forms for additional responsibility in the following areas: reviewing of the videotapes to transcribe the verbal content, removing any identifying information and any and all resulting transcripts.

Again, on behalf of the Calgary Counselling Centre, we support Ms. Russell's participation in our Eating Disorders Program and look forward to the results of her research.

Sincerely,

Robbie Babins-Wagner

Robbie Babins-Wagner, MSW, RSW
Executive Director

Calgary Counselling Centre
Formerly The Pastoral Institute
Suite 200, 940 - 6 Avenue S.W., Calgary, Alberta, Canada T2P 3T1
Telephone (403) 265-4980 Facsimile (403) 265-8886

Family Therapy
Couple Counselling
Individual Counselling
Group Counselling
Depression
Stress
Eating Disorders
Separation and Loss
Parent-Child Conflict
Family Violence
Sexual Abuse
Children of Divorce
Child Behaviour Problems
Marriage Preparation
Employee and Family Assistance Programs

Appendix G: Letter of Clarification from Calgary Counseling Center

To EDPS Ethics Review Committee;

I understand that some more detailed information is required from our agency before ethical approval can be given to Ms. Russell. Therefore I will outline agency policy and responsibility in relation to the proposed research study entitled **Group Themes: Reflections from Group Therapy for Eating Disorders.**

1. Any video tapes are property and responsibility of the Calgary Counseling Center and may not be removed from the premises. For purposes of this study, the Calgary Counseling Center takes full responsibility for the recording, storage, and disposal of the videotapes.

2. Agency policy requires that the videotapes be erased by a mechanical erasing machine after seven years. (Point 1b)

3. All videos are stored in a locked room at the Calgary Counseling Centre. No videotapes have any identifying information on the label. (Point 1b)

4. If a participant requests erasure of the video anytime, all group data is erased. In this case, all 14 videotapes would be completely erased. (Point 6)

5. Although no simultaneous psychotherapy group exists for people who choose not to be in research, a non-research group would be provided for any individuals requesting such as soon as possible. In the mean time, individual counseling would be immediately available. (Point 1c)

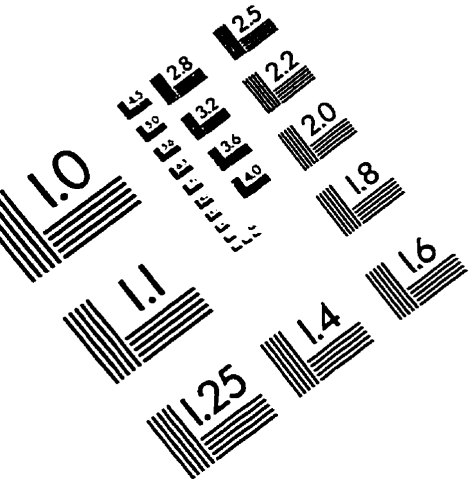
6. The agency agrees to allow Ms. Russell to transcribe the verbal content from our videotapes, removing any identifying information. Transcription storage and disposal is the responsibility of Ms. Russell.

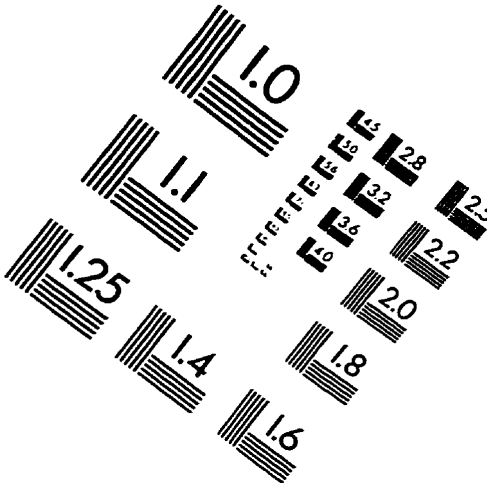
7. Agency policy requires the employees of the Calgary Counseling Center to explain fully the risks, benefits and limits of confidentiality before consent forms are signed.

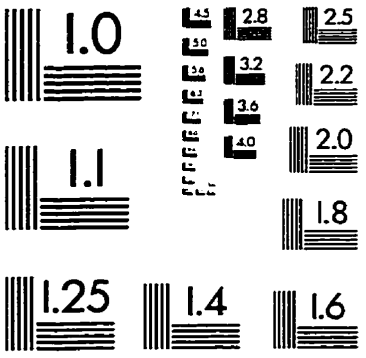
Again, on behalf of the Calgary Counseling Centre, we support Ms. Russell's participation in our Eating Disorders Program.

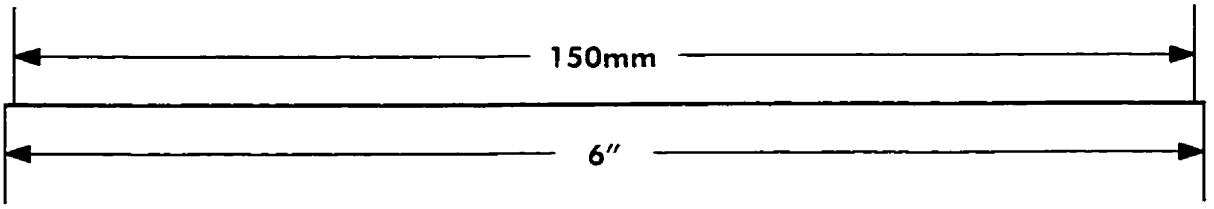
Sincerely,
Robbie Babins-Wagner. Feb 7/97.
Robbie Babins-Wagner
Executive Director

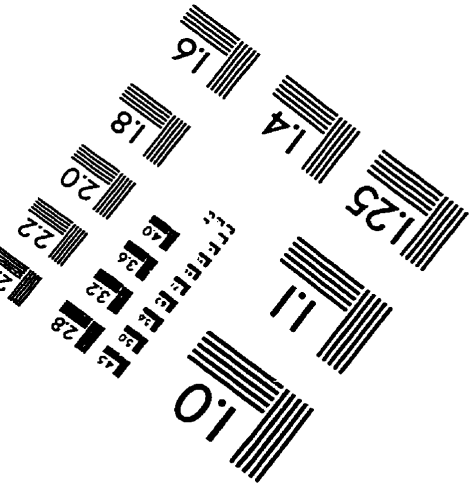
IMAGE EVALUATION TEST TARGET (QA-3)

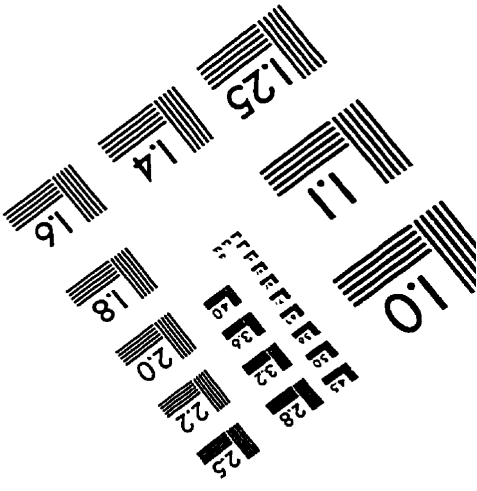












APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989