NARRATIVE THERAPY
WITH
ADOLESCENT FEMALES
WITH EATING DISTURBED BEHAVIOR

By

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A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
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ABSTRACT

Narrative therapy is based on postmodern, constructivist theory about human behavior that focuses on the unique experiences of individuals, and their abilities to create their own realities, rather than on abstract, "expert" opinions about truth or the nature of reality. The student completed this practicum in order to acquire knowledge and skills in the practice of narrative therapy with individual adolescent females having eating disturbed behavior as one of their presenting problems. Sessions were conducted with 8 clients of a counselling centre for children and adolescents located in southern Manitoba. Literature reviews on narrative therapy, eating disturbed behavior, and adolescent females precede a description of methodology, findings, and conclusions. Qualitative research methods provide the framework for presentation of client themes, evaluation of student practice and learning, and client progress.

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CHAPTER 1

Introduction

Educational Objectives

The objectives in undertaking this practicum are: (a) to learn the theory and implement the techniques of narrative therapy into clinical practice, and (b) to use this approach in working with adolescent females whose presenting problems include eating disturbed behavior, viewed as a continuum of behaviors, with anorexia and bulimia at the extreme ends (Brown, 1993c). The scope of this project is limited by the exclusion of eating disturbed behavior involving life threatening situations, medical causes, or obesity.

It was anticipated that the practice of narrative therapy would prove to be as rewarding as the experience of learning the theory. The optimistic tone of narrative therapy, with its focus on clients' potential, helps to promote the therapist's belief in the power of clients to change, and prevents the ever-present danger of becoming mired in pathology and overwhelmed by clients' problems. It is a challenge to learn and practise techniques that are based on the belief in "the profound effects of conversation, language, and stories on both therapist and client" (O'Hanlon, 1994, p. 28).

It was anticipated that practicum findings would demonstrate that narrative therapy is well suited to work with adolescents, including those with eating disturbed behavior. The extent to which narrative therapy is effectively practised is demonstrated in the implementation of its theory and techniques so that positive changes in clients' day-to-day lives become evident to clients, their families, and the therapist. Evaluation is based on qualitative analysis of taped and transcribed therapy sessions. Research

questions focus on implementation of narrative therapy principles, examining themes arising among clients, and evaluation of clients' progress through a subjective process of analysis.

Rationale

Relevance to Social Work

The topic of narrative therapy and eating disturbed behavior is well suited to a social work approach for a number of reasons; specifically its emphasis on the relevance of social context, empowerment, and political issues. Narrative therapy fits well with the social work focus on the context of problems, for example the emphasis on family therapy, systems, sociocultural and political influences, rather than focusing mainly on problems being situated in individuals. It demonstrates the social work interest in issues of social justice and equality for all human beings, and in changing societal structures that marginalize certain segments of society, such as the poor, women, children, non-caucasian races, and psychiatric patients. As well, "the emphasis on mobilizing strengths is in the best tradition of the social work profession" (Kelley, 1996, p. 477).

The fact that most clients of eating programs are female (Wilson & Fairburn, 1998) reflects the influence of gender-based cultural attitudes on the problem of eating disturbed behavior. Hoek (1995) states that, based on clinical samples, males comprise "only five to ten per cent of patients with an eating disorder" (p. 207). The much greater prevalence of eating disorders in Western societies also attests to the contextual nature of this problem, as described by Malson (1998) who claims it is:

> widely accepted that diagnoses of 'anorexia' predominantly occur in young

> Western women and that such diagnoses have become increasingly common in the latter part of this century at a time when research also suggests that increasing numbers of girls and women in the general population are similarly experiencing some degree of distress around eating and not eating, losing and gaining weight, being fat or thin. (p. 5)

The narrative perspective fits well with social work values in its "exploration of the unique, rather than the general, and . . . sensitivity to the context, not independence from it" (Gorman, 1993, p. 251). One of the implications of this perspective for social work practice is that, as stated by Polkinghorne, there is no one model or approach of therapy capable of fitting the complex lived experience of all clients since that experience encompasses so many different aspects e.g., sociocultural, familial, and personal narratives (cited in Cheung, 1998).

The Impact of Eating Disturbed Behavior

The actual prevalence of eating disturbed behavior in the general population is difficult to determine (Hoek, 1995). Research tends to focus on the "high-risk populations such as schoolgirls or female college students" and on the diagnostic criteria for anorexia nervosa and bulimia nervosa (Hoek, p. 208). Hoek cites figures of .28 per cent for anorexia nervosa and 1.0 per cent for bulimia nervosa. According to Garfinkel (1995), "serious forms of the eating disorders affect two per cent of the female population, and more mild variants are probably five times as common. Morbidity and mortality associated with these states is considerable" (p. vii).

Treatment Success With Eating Disturbed Behavior

The success rate in treating people with eating disorders has not been high; only one-half to two-thirds of the population substantially benefit from treatment (Fairburn, 1997). Cognitive behavioral therapy, which is recommended as the treatment of choice for bulimia nervosa, based on scientific research, helps about 50 per cent of subjects (Wilson and Fairburn, 1998). Hsu (1995) states that "about 50 % of bulimia nervosa patients are asymptomatic 2 to 10 years after intake"; 20 % remain chronic; and "about 30% have a course of illness characterized either by remissions and relapses or by persistent but subsyndromal bulimic behavior" (p. 244). Steinhausen (1995) describes how "on the average, more than 40 % of anorexics recover, one-third improve, and 20 % have a chronic course" (p. 235).

As traditional therapies have not proven beneficial to a good number of clients, it appears appropriate to attempt new approaches such as narrative therapy with this client population. Narrative therapists have reported success in working in the area of eating disorders based on case studies demonstrating the alleviation of eating disturbed behaviors (e.g., White & Epston, 1990; Zimmerman & Dickerson, 1994; Epston, Morris, & Maisel, 1995; Eron & Lund, 1996; and Madigan, 1998).

Why Adolescents?

The greater the length of a problem history, the more entrenched it becomes, and the more difficult it is to alleviate the problem (Zimmerman & Dickerson, 1996), so the idea of working with adolescents seems appropriate for a time-limited practicum. Support for this comes from several authors who have documented how eating disturbed behavior

tends to emerge during adolescence, while a majority of the clinical research has been done with adult women. Mitchell, Hoberman, Peterson, Mussell, and Pyle (1996) state that "although bulimia nervosa commonly begins in adolescence and appears to be the most common disorder in epidemiological studies of adolescents, generally only adults have been included in treatment studies" (p. 221). According to Wilson and Fairburn (1998), anorexia tends to emerge in adolescence, while bulimia becomes evident more in young adulthood. In comparing anorexia to bulimia, Wilson and Fairburn state that, to a large degree, there has been much less research done on anorexia because there are fewer people with that disorder; they do not view themselves as having a problem, and are more difficult to engage and maintain in treatment; and there is no cognitive behavioral treatment manual available as there has been for bulimia since the early 1980's (Fairburn, 1997).

The Scarcity of Resources

According to information shared in a public forum held at the Health Sciences Centre on January 11, 1999, the Winnipeg Hospital Authority Mental Health and Child Health Programs are in the process of developing a proposal to address the needs of Manitoba adolescents and young adults suffering from eating disorders. At this meeting there was discussion about parents in Manitoba having joined together to form the Eating Disorders Association of Manitoba to provide support for each other and their families, help in obtaining therapy, and to lobby for more treatment resources. Many parents have had difficulty finding information about available resources when seeking help for adolescent family members.

CHAPTER 2

Literature Review

Narrative Therapy

The concept of narrative therapy emerged during the 1980's and gained popularity in North America after the seminal publication in 1990 of the book, Narrative means to therapeutic ends, written by therapist/authors White and Epston (Kelley, 1996). Narrative therapy refers to a clinical approach which assumes that the way in which "people organize, account for, and make sense of their experiences" is through narratives (Anderson & Levin, 1997, p. 276). In other words, "realities are organized and maintained through stories" (Freedman & Combs, 1996, p. 29).

In this report, the word narrative encompasses "conversations, discourses and stories" (Cheung, 1998, p. 5). Cheung cites Sarbin, Mishler, and Reissman in describing the chronological nature of a story--its structure of beginning, middle, and end, as well as its sequences of themes and implied consequences. Discourse has been defined by Rachel Hare-Mustin as "a system of statements, practices, and institutional structures that share common values" (as cited in Freedman & Combs, 1996, p. 42). There are different types of narratives. Griffith and Griffith (1994) describe self-narratives as "those stories of personal experience that define one's sense of selfhood", and use the words of Gergen and Gergen -- 'who I am as a person' (p. 113). Family narratives and dominant cultural narratives involve ways of acting and thinking that are condoned by, respectively, a particular family or a particular culture (Freedman & Combs).

The term "narrative therapy" can be used to broadly refer to the work of therapists

whose approach presumes that narratives are the main focus of change within the therapy process (Laird, 1995). Narrative therapies assume that when clients construct new narratives about themselves, other people, society, or the world, this results in changes in their own behaviors, feelings, thoughts, and other aspects of their life experience. Rather than focusing on any particular aspects of a person's experience, the focus is on that person's perceived experience as a whole.

White & Epston (1990) describe people coming to therapy "when the narratives in which they are 'storying' their experience, and/or in which they are having their experience 'storied' by others, do not sufficiently represent their lived experience, and that, in these circumstances, there will be significant aspects of their lived experience that contradict these dominant narratives" (p. 14-15). The authors describe the desired outcome of therapy as clients being able to replace those dominant stories with preferred alternative stories that allow them to construct more fulfilling, desirable life experiences.

Social Constructionism

One of the underlying concepts in narrative therapy involves skepticism toward empirical scientific thought for its reliance on "objectivity, rationality, and knowing through observation" (Kelley, 1996, p. 462) and its search for generalizations, abstract ideas or theories to explain human experience (Freedman & Combs, 1996). This is congruent with postmodern thought which rejects the idea of one universal, absolute truth or objective reality that stands out as an abstract phenomenon separate from the reality perceived by each individual person in interpreting his/her own experiences (Nichols & Schwartz, 1995). Rooted in this type of thought, the idea of social constructionism holds

that "people construct their realities as they live them" so that knowledge, beliefs, customs, and all aspects of reality "arise through social interaction over time" (Freedman & Combs, p. 23). Each person has a unique view of reality based on her/his own behaviors, thoughts, and feelings which both influence and are influenced by the historical, sociocultural, and political structures of the society in which she/he lives. A person's experience is created through the interaction between that person and other people as they communicate with each other through language, including both verbal and nonverbal communication in which meaning is subject to multiple interpretations. Language can be described as a metaphor for experience and as "the linguistically mediated and contextually relevant meaning that is interactively generated through the medium of words and other communicative action" (Anderson & Goolishian, 1988, p. 377).

The Link Between Knowledge and Power

According to McCabe and Peterson, the word narrative comes from the latin word gnarus meaning knowledge (Cheung, 1998). I am defining knowledge as the ideas and values that people hold to be true and allow to influence how they live their lives. Knowledge is powerful in the authority it wields over how people make choices affecting their life experiences, and over how broad or limited they view their range of choices to be. Narrative therapy is strongly influenced by the ideas of philosopher Foucault who claimed that it is the people with power in society who determine societal institutions, beliefs, and values (Nichols & Schwartz, 1995). Those with less power become marginalized groups in society whose needs are not met by such discourse or dominant

stories, and whose own stories, based on their own lived experiences, are "subjugated" by the dominant ones held by the more powerful (White & Epston, 1990).

Madigan (1998) states that discourse "is affected at the level of what can be said when, who can say what, and with what authority" (p. 87). Narrative therapy can be viewed as a political process in the fact that it involves helping clients to examine and question dominant discourses of society, to oppose those discourses that do not promote their own interests, and to determine what alternative discourses better meet their needs (Zimmerman & Dickerson, 1994b). In that respect narrative therapy represents a mode of linking together clinical practice and social action which have tended to be separated in the field of social work (Gorman, 1993).

Values

For narrative therapy to be effective the therapist adopts a certain approach, way of being, or world view rather than simply practice techniques (Madigan, 1998). This approach requires the therapist to treat all stories as equally valid or true for the persons telling the story, not believe in any absolute truth or reality, and to believe that the person is not the problem--the problem is the problem (O'Hanlon, 1994). Narrative therapists do not claim to be objective and impartial. They are aware of their beliefs and values, examine these beliefs on an ongoing basis, and are open to changing concepts that no longer fit their preferred experience (Zimmerman & Dickerson, 1996). Narrative therapy incorporates seemingly contradictory social work values including "self-determination and respect for the dignity and worth of each individual [as well as] connectedness and the aims of social justice" (Laird, 1995, p. 152).

The Client-Therapist Relationship

A person is viewed as being multi-storied, having multiple personalities or versions, having knowledge, and being fluid rather than fixed in one particular identity or personality (Madigan, 1997). Clients with anorexia or bulimia are viewed as multi-faceted persons having the resources to choose and live out alternate, preferred realities to the painful story currently dominant in their lives. While clients at first may view other people as helping to create or perpetuate the problem, the narrative therapist sees these other people as part of the context in which the problem was created, having unknowingly "co-operated with the creation of a problem story" (Zimmerman & Dickerson, 1996, p. 54).

Collaboration between therapist and client is viewed as a vital aspect of narrative-oriented therapies, with clients considered to be consultants to themselves and to therapists (Kelley, 1996). This emphasizes the importance of therapists being sensitive to the power issues inherent in the therapist-client relationship. "As mental health professionals our culture awards us tremendous privilege and power in our story telling rights regarding persons and problems" (Madigan, 1998, p. 105).

Therapists taking what Anderson and Goolishian call a "not knowing", rather than an "expert" stance with clients, can promote a less hierarchical relationship between therapists and clients (as cited in Laird, 1995). The narrative therapist focuses on listening to and understanding each particular client's narratives with the view that clients, not therapists, are the experts on the clients' experiences and on how they should live their lives (Freedman & Combs, 1996). As well, therapists' "not knowing" helps to promote

the respect shown toward clients and also "invites curiosity in the quest for more information" (Parry & Doan, 1994, p. 146). Therapists' openness to learning as much information as possible from clients' voices prevents therapists from having a premature sense of understanding clients on the basis of their own assumptions, theories, or personal experience.

Therapists need the ability to create an atmosphere in which clients feel understood, accepted, and comfortable enough to reveal experiences. Therapists need the ability to both listen and ask questions "in a way that brings forth an awareness of either assumption that narratives are built on or gaps and ambiguities in people's narratives, [so that] space opens for stories to shift as they are being told" (Freedman & Combs, 1996, p. 56). Promoting reflexivity is also valuable to the therapy process since it involves " 'the act of making oneself an object of one's own observations' " (Lax as cited in Laird, 1995, p. 158). Therapists need to be aware of and transparent about their own narratives as separate from clients' experiences, while at the same time acknowledging that "therapeutic dialogue is an intersubjective co-creation of meaning between the therapist and the client" (Cheung, 1998, p. 7).

Therapists must recognize the power of language and be skilled in incorporating clients' vocabularies within the therapeutic conversation and help clients change vocabularies in ways that open up the most possibilities and choices. "The role of the therapist is that of a master conversational artist--an architect of dialogue--whose expertise is in creating a space for and facilitating a dialogical conversation. The therapist is a participant-observer and a participant-manager of the therapeutic conversation"

(Anderson & Goolishian, 1988, p. 372).

Intervention

Narrative therapy views problems as situated within discourse. Problems are thus located outside the person and within a dominant or dominating story. Externalizing conversation about the problem is a constant throughout therapy, and involves talking about the problem as an external object, situated "in a meaning system rather than in persons or relationships" (Zimmerman & Dickerson, 1996, p. 49). This results in the separation of the person's identity from the problem, and the objectification of "subjugating 'truths'" instead of people (Zimmerman & Dickerson, p. 63). White and Epston (1990) describe ways that externalization of the problem facilitates clients taking responsibility for the degree to which they are affected by the problem. They claim that the externalization process:

1. Decreases unproductive conflict between persons, including those disputes over who is responsible for the problem;
2. Undermines the sense of failure that has developed for many persons in response to the continuing existence of the problem despite their attempts to resolve it;
3. Paves the way for persons to cooperate with each other, to unite in a struggle against the problem, and to escape its influence in their lives and relationships;
4. Opens up new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence;
5. Frees persons to take a lighter, more effective, and less stressed approach to

'deadly serious' problems; and

6. Presents options for dialogue, rather than monologue, about the problem. (p. 39-40)

The phase of co-construction of the problem which is usually most prevalent in the earlier stages of therapy, allows the therapist and client to examine and evaluate the nature of the problem and its effects. Deconstruction of the problem story follows, and can be described as a "practice of questioning or challenging what is considered 'given' or 'taken for granted' or viewed as a 'settled certainty' by looking at the factors producing these givens" (Zimmerman & Dickerson, 1996, p. 63), and "situating them in cultural, historical and gender contexts" (Epston et al., 1995, p.77).

Pointing out unique outcomes is an ongoing practice whereby the therapist helps the client notice points of access to the alternative story--times when clients' behaviors, feelings or thoughts do not fit the problem story (White & Epston, 1990). Thickening the preferred story refers to enlarging on unique outcomes so that therapeutic conversation tends to focus more on aspects of the preferred story rather than the problem story.

Narrative therapy tends to be a "back-and-forth . . . . unfolding process of externalizing, deconstructing, extending the field of influence of the problem, searching for unique outcomes, finding a history of the contradictions, and continuing to develop and maintain whatever alternative story evolves" (Zimmerman & Dickerson, 1996, p. 88). Parry and Doan (1994) state that "deconstruction and re-vision are not separate processes, but are equally important and inescapably linked. Deconstruction opens space for story re-vision, and re-vision provides the opportunity for further deconstruction" (p. 45).

Revision refers to re-authoring, revising or changing a story so that it is "based no longer on reactions over which she/he feels little control or even responsibility, but upon immediate choices and improvisations" (Parry & Doan, p. 43).

The progress of therapy is slower when the problem has a long history, has become a "lifestyle" or "career", and has been supported by traditional psychological/psychiatric treatments (Zimmerman & Dickerson, 1996, p. 81). The shift in focus from one process to another, from the influence of the problem to more preferred alternatives, is governed by clues provided by the clients, so that the therapist follows the client (Zimmerman & Dickerson, p. 59). For example, if the client cannot point to any preferred developments, the therapist might need to focus again on effects of the problem, or on additional ways of constructing and externalizing the problem (Zimmerman & Dickerson).

Eating Disturbed Behavior

Definition

The DSM-IV refers to "eating disorders" as divided into three separate classifications: anorexia nervosa, bulimia nervosa, and the atypical eating disorders, which do not fit the criteria of the first two classifications (American Psychiatric Association, 1994). However, anorexia and bulimia are typically viewed as extreme points of a continuum on which lie a major proportion of all women who experience varying degrees of "weight preoccupation" (Brown, 1993c, p.53).

Both anorexia and bulimia can involve similar eating disturbed behaviors including stringent dieting, frequent fasting, bingeing, excessive exercising and purging

tactics such as vomiting and abuse of laxatives, diuretics, diet pills or ipecac (Mitchell, 1995). However, people dealing with anorexia appear more successful in losing weight by food restriction. The most severely affected persons look like concentration camp victims (Epston et al., 1995). People dealing mainly with bulimia (i.e. a pattern of alternating binge eating and purging to such extremes as many times per day) tend to be at or close to "normal" weight (Fairburn, 1998, p. 506). People in both groups feel out of control with respect to food; however, the emotional pain related to the experience of losing control is more evident in bulimia due to frequent binge eating (Fairburn, 1997).

History

The meaning given to eating disturbed behaviors has varied over the centuries according to the cultural, political, religious, and medical discourses that existed at the time. Malson (1998) points out that during the twentieth century alone, the medical definitions of these problems were evolving as evidenced by criteria changes in percentage of body weight lost, particular number of menstrual periods missed, or number of binges per week. These repeated attempts to classify eating disturbed behaviors and make them into abstract truths demonstrate the extent to which such abstractions are socially constructed categories "with particular connotations and consequences for girls and women" (Malson, p. 99). Throughout history, discussions about causes and possible methods of treatment for eating disturbed behavior are related to whatever medical practices are currently dominant.

Anorexia

Sir William Gull in England and Charles Laseque in France made the first

references to anorexia nervosa in the medical literature at about the same time in 1873 (Bemporad, 1996). The term "anorexia" refers to a lack of appetite or hunger, which does not accurately fit current views that the problem develops through ignoring or denying strong sensations of hunger for the sake of losing weight (Steiner-Adair, 1994, p. 390).

Bemporad (1996) refers to historical accounts of self-starvation motivated by a variety of factors other than losing weight. With respect to Christianity, there were women who chose to devote their lives to God, which involved helping other people, denying their own "corporeal needs" (Bemporad, p. 222), and fasting as a means to attain the ability to "communicate directly with God" (p. 222). Many of these women were revered and made saints by the church. At the same time they were able to avoid arranged marriages, child bearing, and parenting roles.

Bulimia

Russell first named and described "bulimia nervosa" in the medical literature in 1979 (Ziolko, 1996). According to Parry-Jones and Parry-Jones (1995), the term "bulimia" referring to "great hunger" (as derived from the Greek "bou" meaning ox-like or great; and "limis" meaning hunger) and demonstrated by excessive eating, has appeared in western European writings for more than 2000 years. These authors also state that there are much fewer early case descriptions of bulimia than there were of fasting.

Parry-Jones & Parry-Jones (1995) state that most reported occurrences of excessive eating seemed to alternate with bouts of fasting or other food deprivation states. During the Middle Ages, people suffering from food deprivation during famines often engaged in periods of voracious eating when the famines ended. The authors point out

that gluttony was considered one of the seven deadly sins by the Roman Catholic religion; and some ascetic nuns used self-induced vomiting as "penance" for their gluttony (p. 146). Bulimia was initially viewed as an organic disorder caused by "vicious, cold humors" or by "parasitic worms" (p. 148), and later in history it was related to physical causes such as gastrointestinal disorders, brain diseases, and head injuries. The authors state that psychological causes were first mentioned in 1701, and increased in popularity so that in the early 20th century the disorder was commonly viewed as part of hysterical symptoms in women. After 1900 it became evident that a number of people with bulimia also had histories of anorexia. Despite apparent ties between these two types of eating problems, bulimia nervosa was made a separate and distinct classification of eating disorders in 1979.

Medical Complications

A number of authors (Garfinkel, Garner, & Kennedy, 1985; Goldbloom & Kennedy, 1995; Mitchell, 1995) have written about the medical complications of extreme cases of eating disturbed behavior. Some of these complications include menstrual irregularities or cessation; gastrointestinal problems such as bloating and constipation; cardiovascular problems such as heart failure, heart rate irregularities, low blood pressure, and cold intolerance; dehydration; electrolyte imbalances such as low potassium levels; anemia; dry skin; dental problems, hand callouses, and enlarged salivary glands due to self-induced vomiting; and, with anorexia, there may be the appearance of fine, soft body hair.

Therapy

The insights and theories of early therapists in this field have had a very strong influence on how eating disturbed behavior is treated today, with the most often used types of therapy being family, cognitive, and psychodynamic therapy (Bemporad, 1996). Despite problematic aspects of these approaches, they have contributed greatly to our understanding of eating disturbed behaviors.

Psychodynamic Therapy.

Psychodynamic therapy is rooted in the medicalization of problems, as it arose from early Freudian psychoanalytic theory within the domain of the medical world in the 19th century. Unlike narrative therapy, which situates the problem within discourse, psychodynamic therapy situates the problem within the person, in intrapsychic processes such as internal conflicts and repression. The person is viewed as a fixed personality having deficits. Change involves the therapist as expert giving insights to the client; the importance of transference in the relationship between the client and the objective therapist; and lengthy time requirements for the therapist to create change in the client (V. C. Dickerson, S. Madigan, & J. L. Zimmerman, personal communication, June 11, 1998).

Early psychoanalytic theories about causation of anorexia included the idea that anorexia was a "defence against and guilt over gratifying" the unconscious wish for oral impregnation (Bemporad, 1996, p. 229). By 1895 Freud was describing anorexia nervosa as a rare but 'well known psychiatric disorder . . . of girls [that] seems to me on careful observation to be a melancholia occurring where sexuality is underdeveloped' (as cited in Bemporad, p. 229).

In writing about her work with patients dealing with anorexia, psychoanalyst Hilde Bruch pointed out the strong sense of powerlessness and lack of self-adequacy as well as the distortion in body image and general perception that were common to her patients (Bemporad, 1996). She described their focus on eating as a means of gaining control over themselves and their environment which included their families. Bruch described her patients as growing up in families where their own needs and wants were not addressed so that they tended to lack an "independent sense of self" and were overly compliant toward their parents' wishes (as cited in Bemporad, p. 230). She saw anorexia as also providing young women an escape from the demands and tasks of adolescence.

Other contributions by Bruch, as described by Cuthill (1991) include the psychological effects of starvation; the idea of the client lacking "hunger awareness" and having emotional needs met by food (p. 23); and the tendency for parents to focus on the importance of appearances and to have high expectations of their children (p. 22).

Family Therapy.

"Minuchin and his colleagues at the Philadelphia Child Guidance Centre and Mara Selvini-Palazzoli in Milan" are renowned for their work with families dealing with anorexia (Shekter-Wolfson, Woodside, & Lackstrom, 1997, p. 23). Minuchin's structural family therapy situated the problem of anorexia in the structure of the person's family of origin.

Minuchin, Rosman, & Baker (1978) describe the therapist, "schooled in feedback circularity" as "challenging" or using "therapeutic strategies directed toward" the key structural characteristics of anorexic families which include "enmeshment,

overprotection, conflict avoidance, rigidity, and the involvement of the symptomatic child in detouring conflict...and, in the process, with supporting the family's use of more functional alternatives" (p. 97). Minuchin's description of psychosomatic family characteristics also include "parental marital stress" (as cited in Shekter-Wolfson et al., 1997, p. 231). The parents' focus on their child's problem allows them to avoid dealing with the problems in their own relationship.

As narrative therapists help people expand on the unique outcomes in their life experiences, structural family therapists seek "to bring the submerged alternatives to the fore" (Minuchin et al., 1978, p. 97). The structural family therapist assumes the role of expert in assuming to know the nature of alternative family interactions that would be functional or healthy for the family, and then imposing these on the family in a very directive manner, including physically re-positioning family members in relation to each other. Narrative therapists, in a more collaborative way, look first to clients to provide examples of unique outcomes they have experienced, and to clients to decide whether they prefer these alternatives (Zimmerman & Dickerson, 1996).

When there is more than one person participating in a session, the narrative therapist would want each person to talk individually rather than encouraging them to talk to each other, since the latter situation would tend to bring out the voice of the problem (Zimmerman & Dickerson, 1996). In that way, each person has a greater opportunity of listening to the other in a reflexive manner without placing problematic intentions onto the other's behavior (p. 105). This contrasts with structural family therapy in which family members are encouraged to talk with each other during the sessions.

Cognitive-Behavioral Therapy.

Cognitive-behavioral therapy became quite popular by the late 1980's, and consists of a merging of behavioral and cognitive psychological theories (Rachman, 1997, p. 3). In 1981 Fairburn produced the first published account on treating bulimia nervosa (Fairburn, 1997, p. 209). His work in this area has resulted in a treatment manual, with scientific research pointing to its superiority in outcome over other approaches to bulimia.

Cognitive-behavioral therapy views problems as situated in learned, self-defeating thoughts and behaviors. People are viewed in terms of their thoughts and behaviors. Therapeutic change occurs through the therapist acting as expert determining and changing the person's faulty schemata to more functional, healthy beliefs. Fairburn (1997) describes two key cognitive characteristics of eating disorders: the tendency to evaluate self-worth on the basis of weight and shape, and a "long-standing negative self-evaluation" (p. 211). He refers to the former as "weight-related self-schemata" and describes the latter as "a general self-schema", a term originated by Vitousek and Hollon (p. 211). In addition, Fairburn points to two other common cognitive characteristics of people with eating disorders: perfectionism, and dichotomous or black and white thinking. He describes the cycle in which these four characteristics work together with the behaviors of "intense and rigid dieting", "binge eating", and "self-induced vomiting/laxative misuse" (p. 212) in creating and maintaining bulimia nervosa. He also includes "negative affect" as a common trigger for binge eating.

Major differences between narrative therapy and cognitive behavioral therapy are

discussed by Griffith and Griffith (1994). They describe how in narrative therapy stories (self-narratives) are changing, while in cognitive behavioral therapy beliefs are changing. The authors state that stories are more all-encompassing, specific, and detailed, and include thoughts, beliefs, behaviors, feelings, and all that makes up experience, with the added dimension of time. In contrast, beliefs are "timeless abstractions" (p. 49) that generalize rather than specify experiences. Stories simply are, while beliefs are interpretations that require "rational justification" (Griffith & Griffith, p. 49) or can be opposed by someone holding a different interpretation. As well, Griffith and Griffith claim that the person telling the story is the authority on the self-narrative since he/she alone has that information, while a belief can be commonly held and tends to assume strength or power according to the extent of power or knowledge held by the person proclaiming that belief.

Feminist Therapy.

The emergence of feminist therapy accompanied the "resurgence" of feminism during the period of 1966-71 (Taylor & Whittier cited in Valentich, 1996, p. 283). Wooley (1995) defines feminism as "first and foremost a political movement that seeks to expand women's rights and opportunities, making them commensurate with those of men" (p. 294).

Feminist therapy is similar to narrative therapy in a number of ways. These include the focus on sociocultural, political and historical contributions to problems; the emphasis on the collaborative, non-hierarchical relationship between client and therapist; the approach as a way of being and thinking rather than a set of techniques; the rejection

of labels for people based on classifying problems as abstract truths; the focus on strength rather than pathology in clients; and the emphasis on the personal as political (Valentich, 1996).

While both therapies recognize the effects of patriarchal discourse on women's problems, feminist therapy seems to emphasize the gender imbalance of power, while narrative therapy includes feminist ideas as one of many aspects of power imbalances among people. In describing "feminist influences on the treatment of eating disorders", Wooley (1995) states that "gender remains the single most powerful organizing influence on behavior" (p. 279), and that traditional approaches to eating disorders acknowledge the influence of the "cultural idealization of thinness" (p. 294), but they do not acknowledge the "cultural construction of gender" as "central to the understanding and treatment of eating disorders" (p. 294).

The feminist approach views eating disturbed behavior as socially constructed, rooted in cultural beliefs, attitudes, and prescriptions for how people should behave and fit into the world. According to Chernin, Friedman, and Woodman, in patriarchal Western society there is the pressure on women to be thin, the objectification of women's bodies, and the devaluation of women and femininity (as cited in Szekely & DeFazio, 1993).

Proportionately fewer men suffer from eating disorders, demonstrating how North American society's gender attitudes play such a major role in this problem (Wilfley & Rodin, 1995). Women's lives are more defined by their bodies than are men's. According to Greenspan (1983), a woman's "body is her power. Men are their brains; women are their bodies. Man is culture; woman is nature" (p. 164). Katzman and Lee (1997) refer to

women's "limited access to other forms of power of self-expression beyond corporeal power" (p. 389).

Brown (1993b) and other feminist writers (Lawrence, Lowenstein, and Orbach) argue that controlling the body is an "accessible and viable way for women to achieve some measure of control in their lives", with thinness and control over eating being related to "greater self-esteem and an increased sense of control" (p. 125).

Nurturing and care of others has traditionally been a major role for women, with a woman's worth as a wife and mother overshadowing the value of her educational or career achievements (Greenspan, 1983; Schwartz & Barrett, 1988). Today, however, women are also expected to be mothers/nurturers, maintain slim bodies, and have careers. Wolf (1994) describes the pressure today on young women to "act like 'real men' and look like 'real women.' " (p. 107). Women are faced with the Superwoman ideal (Cauwells, 1983), with increased responsibilities and stress levels. Facing these daunting pressures, it is easy to understand how difficult adolescence can be for young women faced with the overwhelming expectations and choices related to the contradictory roles that face them as adults (Steiner-Adair, 1991). Women are given the message that they can do whatever men can do, but societal structures, such as lack of accessible child care and inequitable pay scales, have not changed to the extent that that attitude is supported. (Brown & Jasper, 1993).

Female Adolescence

Adolescence is "the period of most rapid growth that human beings consciously experience" (Unger & Crawford, 1996, p. 280). Biological changes, both internal and

external, accompany the development of reproductive abilities. Profound physical, emotional, cognitive, and social changes mark the transition from childhood into adulthood, with each individual's experience being highly influenced by the context or external situation of her/his life (Bayrakal, 1987). Adolescence, in our society, has traditionally been viewed as a time of turmoil for teenagers as well as for their parents who need to cope with the effects of these changes on family relationships, as adolescents strive toward autonomy (Oldham, 1980; Preto, 1988; Offer, 1987).

Self-Concept/Identity

Developmental theories about adolescence focus on adolescence as a time of formation of a sense of self or identity with "self-awareness" and "self-reflectivity" as major components (Erikson, Marcia, &Offer cited in Stern, 1991, p. 107). For adolescent females there is often a "disavowing of the self" when they instead begin to "renounce and devalue their perceptions, beliefs, thoughts, and feelings" (Stern, p. 105).

Horney, Thompson, and Deutsch describe adolescence as a time when females's self-esteem drops as they are required to adopt "male-defined values and goals" (as cited in Stern, 1991, p. 106). Gilligan (1982) writes about the differences between how females and males develop and mature, and how female adolescence presents a more difficult time because females' life experiences have contributed to a different world view from males, a world view that is considered inferior to males' in developmental maturity. From childhood, women are geared toward being more caring, empathic, and attuned to the needs of the people around them, while men are raised to be more competitive, aggressive, and autonomous. Gilligan describes how North American or dominant culture

has tended to idealize traditional masculine characteristics of individualism, separation, objectivity, detachment, and the abstract, while considering traditional female qualities (e.g., interdependence, connection, subjectivity, and relativism) to be of secondary value.

Seligman states that " 'girls, at least up to puberty, are more noticeably optimistic than boys,' and concludes that 'whatever causes the huge difference in depression in adulthood, with women twice as vulnerable as men, it does not have its roots in childhood. Something must happen at or shortly after puberty that causes a flip-flop--and hits girls very hard indeed' " (cited in Gilligan, Rogers, & Tolman, 1991, p. 13).

Body Image

Female adolescents experience heightened concerns about their own physical appearance and thinness at the same time that their bodies are becoming larger, with a general increase in the percentage of body fat, especially around breast and hip areas (Santrock & Yussen, 1987). Steiner-Adair has proposed that this accumulation of body fat can contribute to females' devaluation of their bodies in a society where body fat signifies "powerlessness, ineffectiveness, and lack of control", as opposed to leanness and muscularity which signify "assertiveness, independence, and self-control" (cited in Brown & Jasper, 1993, p. 30).

Relationships

Relationship issues in adolescence are especially difficult for females, since they tend to be more relationship-oriented than males, more sensitive to the opinions of others, more affected by the increased focus put on the sexual attributes of their bodies, and are faced with the attitude of the male-female double standard regarding sexual activity

(Friedman, 1997). Steiner-Adair describes how females' social lives are affected by their increased involvement with males within a culture that values women as the primary caregivers; as the ones assuming more of the responsibility for heterosexual relationships; and as the ones attempting to reduce conflict by equating others' needs with their own (as cited in Brown & Jasper, 1993).

Therapy

General Concerns.

The following examples from the literature describe some concerns about doing therapy with adolescents. With younger teenagers, especially, their ability to deal with abstract issues may be less well developed, and the ability to establish relationships with them may be thwarted by the constrictions of sitting in a room rather than doing some activity together (Wallbridge & Osachuk, 1995). Adolescents tend to place more value on the influence and approval of their peers rather than of adults (Preto, 1988). They may be more reluctant to enter therapy, may tend to miss appointments, and may drop out of therapy prematurely. "Resistance is considered a particular challenge in clinical work with adolescent girls, who are known as difficult to treat precisely because of the strength of their resistance and their tendency to leave psychotherapy prematurely (Gilligan et al., 1991, p. 1). From a narrative standpoint, it is preferable to believe the problem lies in the therapy style (such as what questions are being asked) rather than in the clients' "resistance" (Amundson & Stewart cited in Smith, 1997).

The Narrative Approach to Adolescence.

Similar to narrative and feminist therapists, Gilligan holds a political,

sociocultural, and historical view that includes women's need to resist the patriarchal, hierarchical order of our society and ensure that women's voices are heard. In her 1993 letter to her readers (Gilligan, 1982), she states that during adolescence young women

> come face to face with a social construction of reality that is at odds with their experience, so that some kind of dissociation becomes inevitable . . . coming not to know what one knows, the difficulty in hearing or listening to one's voice, the disconnection between mind and body, thoughts and feelings, and the use of one's voice to cover rather than to convey one's inner world. (p. xxi)

Narrative therapists view developmental theories as often being used in ways that tend to marginalize people who do not fit the "normal" developmental stages that were created by and based on white, middle class, male standards (V. C. Dickerson, S. Madigan, & J. L. Zimmerman, personal communication, June 11, 1998). Children and parents tend to view themselves as defective and inferior if family members do not meet these standardized prescriptions of normality. Narrative therapists might use whatever aspects of these theories seem to fit for the particular client in a way that is helpful and empowering for the client. However, there is no assumption by those therapists that these theories are idealized "truths".

Zimmerman and Dickerson (1996) provide their opinion about the cultural discourse of adolescence that includes the idea that parents are held responsible for their children growing into "independent, worthwhile" adults (p. 53):

> We believe that the cultural discourse about adolescents' needing to separate from their parents and find their own identity influences parents to take on the task of

> making sure their children do this in highly prescribed ways. Situations are set up in which parents and adolescents become competitors for the "right" way, rather than allies in a process of adolescents beginning to narrate their own stories. (p. 53)

Eron and Lund (1996) describe the narrative approach to work with parents and teens as "focused more on forging new connections between family members rather than emphasizing generational boundaries" (p. 158). Parry and Doan (1994) discuss their use of the metaphor "parenting to prepare versus parenting to protect" as helpful in dealing with parents and adolescents (p. 72-75).

In the literature, some narrative therapists discuss the value of having access to an archive of tapes or writings of people who have successfully overcome problems similar to those of the clients (Epston et al., 1995; Zimmerman & Dickerson, 1996). This idea seems especially suitable to work with adolescents whose tendency is to accept guidance more readily from peers than from adults, and to seek conformity with their peers. The archives can be shown to clients to help them notice and express the nature and effects of problems they share with other people, and to provide clients with information about possible tactics to fight the problem. The credibility of these tactics is enhanced by the fact that they are coming from people like themselves, adolescents with similar problems, rather than adult "experts". Also, access to the archives may relieve some of the clients' sense of isolation in facing the problem, by offering them "communities of concern", a phrase used by Madigan and Epston (cited in Nylund & Ceske, 1997). Thus problems such as depression and anorexia can be "de-privatized" and viewed more as socially

constructed (Madigan, 1998, p. 93).

The suitability of narrative therapy for working with adolescents is described by Weingarten (1997, p. 309):

> Postmodern practices, with their emphasis on the development of the clients' voice rather than the assertion of the therapist's voice, seem particularly useful for work with children and adolescents. Their stories are particularly vulnerable to colonization; their voices are particularly vulnerable to silencing. A postmodern practice can guard against the imposition of meaning on persons who, like children and adolescents, are less powerful than adults and whose stories may be less precisely formed (Stacey & Loptson, 1995).

CHAPTER 3

Methodology

Setting

The setting for this practicum is the Community Service Program of the Manitoba Adolescent Treatment Centre (MATC) at 228 Maryland Street in Winnipeg. MATC provides acute and long term psychiatric treatment services for children, adolescents, and their families. Therapy is provided by clinicians of various backgrounds including social work, psychiatry, psychology, occupational therapy, and nursing. The focus is on children and adolescents who are unable to find services in any other resource or organization, and whose problems are related to trauma, abuse or mental health issues.

Client Criteria

The practicum is based on having six to eight clients, with a minimum of four being required for completion of the practicum. Adolescent females aged 12 to 17 have been chosen from intakes at the MATC practicum setting and from the waiting list of potential eating disorder clients for the Health Sciences Centre psychiatry outpatient unit. Twelve to sixteen people would be screened in interviews, and six to eight of those were to be chosen to be participants based on the following criteria:

--extreme dissatisfaction with their current body weight and intense fear of gaining weight.

--engagement in any of the following behaviors: stringent dieting; frequent fasting; excessive exercising; self-induced vomiting; abuse of such drugs as laxatives, diuretics, or diet pills; and binge eating (the process of overeating accompanied by a strong sense of

losing self-control, and extreme feelings of sadness, guilt, and self-hatred).

--no previous history of hospitalization regarding eating disturbed behavior.

--willingness to provide (if requested) verification by a medical doctor of no evidence of physical health problems.

--their own desire and willingness to attend therapy.

--reliable means of transportation to therapy sessions.

--no diagnosed mental health problems.

Screening

An initial screening session provides a meeting with clients and their parents to discuss issues of confidentiality and the compatibility of their goals for therapy with the practicum approach. Student status, the use of audiotaped sessions, sharing of information with supervisors, and the time limits of involvement are discussed; and consent forms are signed (see Appendices B, C and D).

Family Involvement

The parents or other interested family members are to be included in the beginning, middle, and end sessions, seen together with the adolescent, or separately, as preferred by the participants. Therapeutic reasons for including family members focus on addressing family issues that are affecting clients' progress in therapy: to reinforce separation of the problem from the adolescent; to discuss with parents how they can best help their daughters in fighting against the problem; to provide information as to the effects of the problem on the clients' relationship with family members; and to provide an audience for clients' success in winning over the problem (Zimmerman & Dickerson,

1996).

Session Content

The practicum structure involves six to eight clients for 12 sessions each over a three month period. As narrative therapy is not a linear process, therapy tends to move from a focus on construction and deconstruction of the problem story, with acknowledgement of unique outcomes, toward an emphasis on development and enlargement of the preferred story. The rationale for having 12 sessions was to allow at least three to four weeks for each phase of the process. If further sessions were required or if clients were not assessed as appropriate for this practicum, they would be provided with alternative services through the MATC Community Services Program or other available resources.

Co-construction of the Problem involves the use of words or phrases that best fit the client's experience of the problem, preferably using the client's own vocabulary. Personification of the problem allows discussion of the problem's "intentions", "beliefs", and "practices" (Epston et al., 1995, p. 74). Clients examine the specific ways in which their own thoughts, feelings, actions, and relationships with others are affected by the problem, with the result that ways of defying and resisting the problem become more evident (Epston et al.). Examples of possible questions to elicit clients' metaphors include: "What would you call the problem that is most affecting you? . . . . What's your main experience when this problem is around? What are you noticing?" (Zimmerman & Dickerson, 1996, p. 303). "Why is it at this time that you have come to see someone like me? . . . . What name might we come up with to describe your current situation?"

(Madigan, 1998, p. 95). "How does the problem direct you? What does it get you to do? . . . What does the problem steal from you? What enjoyment has it taken from you? . . . . What kinds of things does it tell you? . . . . What does it tell you about yourself? About your . . . (mother, father, etc.)?" (Zimmerman & Dickerson, p. 304).

Deconstruction of the problem involves "directly challenging personal and cultural stories that have contributed to the evolution of the problem" (Zimmerman & Dickerson, 1996, p. 304). This involves the "unmasking" or "exposing" of the problem which allows clients to become aware of how they became "recruited into [the problem's] realities and practices" (Epston et al., 1995, p. 77). This reduces the power of those "truths" over clients, strengthening clients' abilities to consider alternative realities and practices. Examples of questions proposed by Madigan (1998) in dealing with the problem of anorexia include: "Are there ways in which anorexia has tricked your mind into thinking that an anorexic life is the best life possible?" (p. 95). "Are there certain structures/beliefs of our society which may be viewed as supporting anorexia? . . . . In your experience what is anorexia's most effective weapon/ strategy?" (p. 97). "In what ways has anorexia affected your relationship with yourself by telling your self that you are not worthy?" (p. 100).

Unique outcomes or problem-free situations may be identified in the past, present, or future, and may be evident within either the landscape of action, events that happen in a sequence, or the landscape of consciousness which refers to meanings, preferences, values, and intentions (Zimmerman & Dickerson, 1996; Parry & Doan, 1994). Examples of questions include "Can you remember qualities of yourself prior to anorexia's onset

that you would like to re-remember? . . . . How were you able to keep your own positive thoughts of yourself alive despite what others were saying? . . . . Can you name the quality in you that has kept you alive all these years despite anorexia's attempts to kill you? . . . . At which time of the day are you most anorexic-free? . . . . How are you able to find this freedom?" (Madigan, 1998, p. 102).

Thickening the preferred story is an extension of the previous phase, and, if therapy is successful, this phase tends to take up a greater and greater portion of each therapy session over time. It involves developing the landscapes of action and consciousness within the past, present, and future. Examples include recounting details of events or actions taken by clients as well as the significance of those actions for them; bringing forth the history or background for the preferred story; having other people involved in the therapy process so that they can be an audience to witness the emergence of the preferred story (Parry & Doan, 1994; White & Epston, 1990); and asking clients to see themselves from another person's point of view (Zimmerman & Dickereson, 1996, p. 102), thereby bringing other characters into the new plot line or "relationships into the therapy room", as described by Michael White (cited in Zimmerman & Dickerson, p. 284).

Examples of questions include: "What strategies do you know about that [anorexia] may have tried to steal away from you, but that you called up on in the past and that you can also use now? . . . . As you win more battles against [anorexia], how will your life look in the future?" (Zimmerman & Dickerson, 1996, p. 305). "What rules of anorexia did you have to breach in order to attend this meeting today?" (Madigan, 1998,

p. 103). "As you see yourself winning more and more battles against [anorexia], how are you thinking of yourself as a person? . . . . Is this something you have known about yourself for a long time?. . . . If I were to tell others about your successes, how do you think I might describe you?" (Zimmerman & Dickerson, p 306). "I wonder who in your . . . family/at your school noticed these fantastic anorexic-free achievements?" (Madigan, p. 103). "As you put [anorexia] behind you, what might you call this new path you are taking in life? . . . . Now that you have made this commitment to yourself, who else would celebrate it with you?" (Zimmerman & Dickerson, p. 306).

Qualitative Analysis

Data is comprised of audiotapes and transcriptions of sessions, and therapist's notes taken during and after sessions. The approach is exploratory and descriptive regarding analysis of : (a) client themes (what themes arise within the client group), (b) practice (how the therapy process is implemented), and (c) client progress (how clients respond to therapy). The qualitative approach provides understandable results in everyday language and emphasizes collaboration with clients. Like narrative therapy, it is descriptive in its analysis of data comprised of events revealed in "people's own written or spoken words and observable behavior" (Taylor & Bogdan, 1998, p. 7); and it is interpretive in exploring what meanings clients make of those events (Maxwell, 1996).

The degree to which the therapy process reveals the phases and aspects of narrative therapy becomes evident by looking at such factors as the following: Were narrative types of questions used in a way that results in problem-externalizing conversation? Has the amount of talk about preferred stories gradually increased over that

of problem stories? Has the co-constructed problem diminished in severity or pervasiveness since therapy began?

Improvement in the client's well-being is anticipated to accompany the successful practice of narrative therapy. Does the client gradually, over time, show signs of increasing assertiveness, self-respect, and self-expression? The degree to which this is true is demonstrated by the client's responses and feedback to the therapeutic process. Parents' reports about their children are also useful in pointing out clients' mood changes and frequency of self-destructive behaviors versus self-enhancing behaviors.

Rationale for Qualitative Research Approach

Subjectivity.

In narrative therapy it is changing narratives that mark successful outcomes. "The narrative changes as a result of a conversation in which both the problem and its possible solutions shift and are reframed" (Laird, 1995, p. 152). Since narratives are not measurable quantitatively nor free of values, "practice cannot be evaluated through some set of objective criteria that exist separate from dialogue" (Laird, p. 159). Qualitative research fits better with narrative therapy because of the richness of detail addressed and its ability to "capture the intricacies of clients' meanings and beliefs as well as the movement of the therapeutic dialogue" (Laird, p. 159). Qualitative research expects and takes into account that there is a close relationship between the researcher and the client with both influencing each other and the nature of the dialogue between them (Tutty, Rothery, & Grinnell Jr., 1996).

Induction.

Like narrative therapy, qualitative research begins with specifics and detail, and moves toward more general themes (Tutty et al., 1996). The approach is inductive in that it uses the specifics and details of situations to create or build theory, knowledge and understanding, rather than deductively using the situations to test already existing hypotheses or theories (Padgett, 1998). Both therapist and researcher attempt to listen to and understand a person's total experience on all levels, including meaning and context of that experience for the person, while attempting to prevent their own preconceptions from influencing this process as much as possible.

Process Focus.

Qualitative research is oriented more toward process than outcome (Maxwell, 1996). This fits with the focus of this practicum which is to examine and improve the therapist's practice of narrative therapy, rather than to evaluate either the efficacy of narrative therapy for a particular client group, or the therapist's level of success as a clinician. The focus of qualitative research is to learn details about unique experiences by examining events within the context of individuals' lives, rather than generalizing findings to other clients and studies (Tutty et al., 1996).

Data Analysis Steps

Tutty et al. (1996, p. 89-119) describe the method of qualitative analysis as follows:

1) "Identifying meaning units" within transcribed tapes.

2) Assigning category names to groups of similar meaning units.

3) "Assigning codes to categories".

4) "Refining and reorganizing codings".

5) "Deciding when to stop".

6) "Retrieving meaning units into categories".

7) "Comparing categories".

8) "Developing conceptual classification systems".

9) "Presenting themes". (p. 89-119)

To determine client themes, the transcripts were read through line by line, while noting in the margin the names for the types of issues being discussed. These issues were listed and combined when similar in nature into categories that were then coded. The transcripts were examined again, with codes placed in the margin. Category names were changed to allow the most condensation possible that best fit the issues. Categories that were found for the majority of the clients were then chosen as themes, and examples of these were used in the write-up of results.

In the analysis of practice, a list of narrative therapy elements were used as a template. Transcripts were analyzed by putting these elements in the margin next to meaning units comprised of lines of transcript that demonstrated those elements. The elements that emerged were listed and placed in a smaller number of more comprehensive categories. These categories were coded and placed in the margins of the transcripts. The final categories that emerged are discussed within the phases of narrative therapy.

CHAPTER 4

Findings

Setting

There have been advantages and disadvantages about the MATC Community Services Program. The intake assessment process is anti-narrative therapy in its focus on diagnosis of psychiatric ailments and on finding pathology. For example, parts of the MATC initial screening forms (see Appendix F) focus on searching for problem areas in addition to presenting problems. The intake form includes a list of thirty-four Presenting Problems to address as to onset, frequency, and duration (e.g., Attachment Problems, Homicide Threat, and Hallucinations). There is also a list of six Family History problems such as Suicide, Psychosis, and Violence. The narrative therapy literature recommends that the initial phone contact comprise the client's view of the presenting problems, and that the initial session begins with getting to know a bit about the client's life outside of problem-saturated stories (Freedman & Combs, 1996; Freeman, Epston, & Lobovits, 1997; Zimmerman & Dickerson, 1996).

At the same time, the psychiatric focus has been helpful since at least one client's situation included somatic symptoms that hindered her ability to work between sessions. This seems to fit with the narrative therapy approach which does not denigrate other therapy approaches, using them as appropriate and beneficial for the individual client who is interested in exploring a certain approach, as possibly fitting well with their needs.

Client Screening and Selection

Limited referrals resulted in client criteria being expanded to include clients for

whom eating disturbed behavior was not a primary therapy issue, although it had been included in their presenting problems at intake. The H.S.C./MATC Intake Person reported that she had been receiving much fewer referrals than usual for this problem area. Some of the practicum referrals involved mothers wanting their daughters to participate in therapy, but their daughters denying the existence of any problems requiring therapy, and refusing to attend more than the screening interview.

The frequency of parent-adolescent conflict about the need for therapy became evident from observing a self-help support group meeting for parents of children with eating disorders (March 23, 1999). In addition to the problem of finding treatment resources within their financial means, parents expressed a strong concern about the refusal of adolescent children to acknowledge their problem and participate in therapy. Some theories explaining the reluctance of adolescents to attend therapy include:

1. Unwillingness of this age group to acknowledge that their eating disturbed behavior is a problem, since appearance is so important to adolescent females, and the value of dieting and striving for thinness are so dominant in our culture. They view the benefits of the behavior as greater than the discomfort or disadvantages involved.

2. Adolescents' tendency to become involved in power struggles with parents and to stop confiding in parents. They may fear their parents will judge them, take away their freedom, give advice or lectures, or become overburdened emotionally by their problems. More adolescents might ask for help if they did not have to have their parents involved. This was stated by psychologist Richard Shore (personal communication, March 30/99) who stated that he receives a good number of calls from adolescents wanting help with

eating problems on condition that their parents are not contacted.

Limited referrals to the practicum by professionals may be related to the tendency for professionals to view this problem area as complicated and requiring a long term commitment from one therapist for more than the three months allotted to this practicum. This idea was discussed at the support group by one of the guest speakers, Dr. Giselle Moirier, psychiatrist at the Eating Disorders Clinic of Health Sciences Centre. She stated that the Clinic has had difficulty attracting psychiatrists to work there. She said that psychiatrists tend to be reluctant to get involved with eating disorders because the patients are considered to be hard to treat; the psychiatrists need to have a strong medical background in order to deal with physical complications; and in the majority of cases, there is comorbidity, such as depression and anxiety disorders. The doctors need to be comfortable with such approaches as psychopharmacology, psychodynamic, and cognitive behavioral therapies, as well as know at what point to refer cases to family therapy.

Data Collection

Each of the eight clients had at least one taped session in addition to the screening session. The number of times clients were seen, not including initial screening sessions, were as follows: One client was seen for only one session. One was seen for three sessions. Two were seen for five sessions each; for one of those two clients, three of the sessions were not taped, as they were held in a restaurant. One client was seen for six sessions plus one untaped psychiatric assessment. One was seen for eight sessions including one untaped restaurant meeting. One was seen for seven sessions plus a follow-

up meeting after almost a 2 ½ month summer break. And one client was seen for 11 sessions plus one untaped psychiatric assessment.

Audiotapes were made of each session, except for one session not taped due to mechanical error; four sessions held outside the office; and two sessions involving psychiatric assessment. First and last session tapes with each client were transcribed, as well as session 5 for Client C, session 6 for Client G, and session 2 for Client H. Detailed notes of the tapes were made for sessions not transcribed word for word.

In earlier sessions extensive note taking slowed down the pace of the session, was distracting to the client, and prevented fully tuning into the client; so a more concise system was developed. Narrative therapists' writings usually mention the importance of note taking to ensure the capturing of clients' vocabulary and phrases in describing their experience.

Data was also collected from intake forms and phone conversations with parents. Phone conversations with school personnel and written assessments from schools were included for two of the clients (see Appendix E).

Client Profiles (see Table 1)

Age

One client was 12 years old; four clients were 13 years old; and three were 17 years old.

Family Type

Four clients lived with both birth parents. Two lived in single parent families (with birth mothers). One lived with birth mother and stepfather. One had just moved into

Table 1

Client Profiles

Client	Age	Family type	Problem Areas	School issues	Family mental health history	Family violence witness	No. sessions with parent/ total no. sessions	Past ther-apy
A	12	2-parent	Anger Family relation-ships	Behav-ior	Depres-sion		3/3	
B	13	1-parent	Sadness Family relation-ships	Acad-emic	Depres-sion Addic-tion	X	3/7	X
C	13	2-parent	Sadness Not good enough	Acad-emic	Addic-tion	X	4/11	X
D	13	1-parent	Anger	Acad-emic	Depres-sion	X	1/5	X
E	13	1-parent	Anger Family relation-ships	Attend-ance	Addic-tion	X	0/5	X
F	17	2-parent	Eating				1/1	
G	17	2-parent	Fat problem				2/8	
H	17	2-parent	Eating Fear	Attend-ance			1/6	X

a two-parent foster home; she had not lived with birth parents for seven years. All parents were employed outside the home. Five of the adolescents were the youngest of their siblings; one was the eldest child; one was a middle child; and one was an only child.

School Issues

All were registered in school; one skipped school frequently; one had not attended for almost two years due to school anxiety issues; and the rest attended regularly. Three of the clients had been previously diagnosed as having learning disabilities.

Problematic Behavior

With respect to eating disturbed behavior, three clients described that problem as a major issue in their lives that they would want addressed in therapy. It was interesting to note that those same clients were the ones who lived in two-parent families without a history of divorce and with relatively higher financial means. Perhaps they were reacting to the higher level of functioning that was expected of them from such influences as parents, teachers, and cultural ideals. One of those had previous therapy regarding eating disturbed behavior. Four other clients had also attended therapy in varying amounts regarding other issues. One client had talked to no one else about her struggle with the eating related problem, and believed that only her parents were aware of it.

Along with varying degrees of concern about eating disturbed behavior, six clients were referred with concerns about extreme sadness or depression. Of those six, three of them were struggling with anger management issues as well. One client had major anxiety issues. One client used drugs or alcohol on a regular basis. There were two clients with eating disturbed behavior as the only presenting problem.

Parental Involvement

There was a range in how much involvement families had, although screening sessions always included the mother (the C.F.S. social worker for the Permanent Ward), and in one case a stepfather as well. There were only two clients for whom mothers did not attend one of the last two sessions. One was the adolescent in care who attended more sporadically. The other was a case in which a final session was never held due in some part to the client's not wanting to return for further sessions. There was only one client for whom the mother did not participate in the first therapy session, at the request of the daughter, who wanted to focus on her own issues. However, the mother had already provided much information during their screening session. One client refused to discuss her struggle with eating related problems in her mother's presence, but allowed her to sit in briefly a couple of times to discuss other issues such as the problem's effect on herself and her husband. One 12 year old client did not want to meet without her mother being there, although she was seen individually during part of one session. There were only three sessions with them, since the daughter stated clearly she did not want to attend therapy. Family therapy was recommended for them.

The mother of one client attended three therapy sessions and part of a fourth session, as well as the psychiatric assessment. That client's sister attended part of one of the sessions as well, since the client thought it would be a good idea to have her participate in discussion about some problem issues between the two of them. The only male parent involved in sessions was that same client's stepfather who attended two appointments (the screening session and a meeting with one of the MATC psychiatrists).

None of the clients wanted their fathers involved. One even forbade her mother to tell her father anything at all about the therapy sessions, although he did know she was attending.

Family Violence

Four of the clients had witnessed marital violence and parents' substance abuse to varying degrees in the past, although fathers involved in those behaviors no longer lived with the client.

Parent Mental Health History

Two of the clients' mothers said they themselves were involved in ongoing psychiatric treatment involving medication and therapy, and had been hospitalized for mental illness in the past. Another one had attempted suicide several years earlier. Two biological fathers were described as having alcohol and/or drug addiction problems.

Eating Disturbed Behavior (see Table 2)

With respect to the three cases where eating disturbed behavior was a focus problem (all age 17), clients had a history of severely restrictive dieting and weight loss that began about the age of 12 years in two of those cases, and at approximately age 16 in the third. Current issues in the two former cases involved purging by self-induced vomiting and in one case the use of laxatives as well; their bingeing episodes did not appear to involve abnormally large amounts of food, but did include feeling a loss of control. Two clients whose current problem focus was not eating related had histories of some degree of eating problems. There was a 13 year old client with a history of not eating at age 9 (factors not explored in this practicum) and currently concerned about overeating for the past two years. Another 13 year old was reported to have been

Table 2

Eating Disturbed Behavior

Client	Age	Age At Presenting Problem Onset	Presenting Problem	Other Past Problem	Age At Past Problem Onset	Previous therapy
A	12	2 ½	Overeating			
B	13	11	Overeating	Under-eating	9 & Under	
C	13	12	Undereating			
D	13	13	Undereating	Self-induced vomiting	10	
E	13	13	Undereating			
F	17	16	Undereating Bingeing			
G	17	15	Bingeing Self-induced vomiting Laxatives	Under-eating	12	
H	17	15	Bingeing Self-induced vomiting	Under-eating	12	X

concerned about being too fat and having self-induced vomiting episodes at about age 10. That situation was not explored in this practicum.

Client Themes (see Table 3)

Control Issues

A common theme among clients has been that they believe they are controlled by their emotions which derive from personal defects and leave them at the mercy of external events over which they have no control. With respect to a bulimia problem, one client stated that "I'd like to have more control [over] my eating . . . . I eat something, then I eat too much, then I like need to get rid of it" (G:01, June 8/99). Another client talked about her feelings of anxiety being out of her control: "So it seems like how I function is determined by my feelings, and they aren't determined by me" (H:01, July 20/99). One client discussed her difficulty with anger: "I don't want to punch a wall, but all of a sudden my hand will just go . . . It feels like my hand just does whatever it wants" (D:01, April 30/99).

A sense of lacking control over their lives is to some extent based on the reality of their having little power in a world where adults such as parents, teachers, and societal values dictate their actions and evaluate their success in meeting adult standards. One client had resumed attending school and claimed that she was continuing to do so at great hardship to her own emotional health. During a session which her mother also attended, she said she was not attending school to fulfill her own needs or wishes, but simply to comply with her parents' demands--"Because if I don't they'd want me to get a job" (H:06, Sept. 2/99). Mother was then told that one of her daughter's fears "which she's

Table 3

Client Themes

Client	Control	Self-criticism	Negative attitude toward school	Parent-teen conflict	Grief/ loss	Body image	Question-able therapy commit-ment
A	X		X	X	X	X	X
B	X	X	X	X	X	X	
C	X	X	X	X	X	X	
D	X	X	X	X	X	X	X
E	X		X	X	X		X
F	X	X			X	X	X
G	X	X	X		X	X	X
H	X	X	X	X	X	X	X

talked to me about in the past is that if she's functioning better, and things are going better with her, then maybe there will be too many demands put on her all at once." The daughter backed up that comment with a response of "Exactly."

One of the problems faced by adolescent females is the pressure they feel from parents, teachers, peers, and external systems to fit into the roles others want them to play, rather than the roles that they perceive to fit for themselves. One client who had lost a lot of weight over several months, complained about people telling her she was "too skinny" and she should "eat something". She referred to "everyone in my life, like my teachers, my friends, my family, neighbors, and I mean there hasn't been one person in my life who hasn't said something" (F:01, April 23/99).

When discussing her parents' concern that she was overweight, one client stated, "Like I don't care if like, if you and my dad say something to me like 'Oh, you should lose weight blah blah blah.' I don't care if you guys think that. Cause I don't. Like I don't care what . . . people think" (A:03, July 20/99). Her weight was one of the reasons her mother wanted her to participate in therapy. She stated that she had told her mother she did not want to attend any further sessions, but was told "No, we have to go" (July 20/99).

Self-criticism

All but two clients were very critical of themselves with respect to appearance, intelligence, or general competence. Comparing themselves to other adolescents, they lamented the fact that they did not get high enough grades, did not perform well enough in sports, looked fat and ugly, could not control their eating, or were simply not good

enough in at least one respect. One client stated that "things just always concentrate on your appearance. It's so futile . . . Just obsessing about how you look" (G:06, August 17/99). Another client wished that she was more popular and outgoing, and described herself as being in the C group of "nerds" at school (C:02, April 1/99). One person kept a journal of how many calories she ate each day, and said that if she ever allowed herself to eat as much as 1000 calories during the day without purging afterwards, she'd "just feel horrible . . . I don't want to have to write it in my little journal that I had that much" (H:01, July 20/99). One client said that "Sometimes I think I'm really stupid and stuff", and her mother added that "She says she's ugly and she says she's fat" (B:01, May 12/99). In discussing perfectionism, another client said that in addition to appearance concerns, she had high expectations of herself "in every way" (G:06, August 17/99).

The two clients who appeared less self-critical, based on what they said during sessions, were also the ones who tended to blame other people for problems in their lives, and who were the least motivated to attend therapy.

Negative Attitude Toward School

All but one client expressed a prevailing dislike of school, where they felt stifled and not listened to. Problems at school included such issues as truancy, unhappiness with school attempts to address special education issues, anger management difficulties and an intense fear of school resulting in non-attendance for almost two years. One client expressed boredom at the repetitive nature of the work covered: "I hate school with a passion . . . God, give us something new to read" (E:01, May 18/99).

Another client complained about the school's involvement in students' personal

lives, describing the principal questioning a misbehaving student: "What were you doing last night? What time did you get home? What time did you go to bed? . . . none of his business." She talked about the school's tendency to label or categorize students as being a bad influence on other students: "they tell the grade sevens not to hang out with us" (D:01, April 20/99).

One client with learning disabilities felt that teachers were condescending toward her:

> Teachers will be extra nice to me and say, 'Oh, do you get that?' They treat me like I'm a little baby and stuff and I don't like that . . . 'That's very good . . .' They think I'm not as smart as the other kids so they need to put some more oomph in me, and say nice things. (B:03, May 26/99)

Students face the peer pressure and class structure of school life, where peers' values may conflict with those of authority figures. One client's mother forbade her association with a particular friend outside school because that friend had used marijuana. That same client complained about not fitting into one of the three groups of people at school--the A, B, or C group: "I talked to the most popular people, and the other ones, there was like all kinds of mixture, so I didn't really have a place exactly" (C:12, July 7/99). Another client described herself as not belonging anywhere at school because she was "in between like the normal people and the popular people" (H:06, Sept. 2/99).

It's not surprising that clients had negative attitudes toward school. Berndt, Dickerson, and Zimmerman (1997) refer to the institution of school as having "developed in the same intellectual time and from the same tradition as the Panopticon (described

very clearly in White & Epston, 1990), which embodies the practices of evaluation, surveillance, comparison, classification, and isolation--all so pervasive and powerful" (p. 444).

Separation from Parents

Although all clients seemed to have closer relationships with their mothers than their fathers, they also had conflictual relationships with their mothers to varying degrees. Problems ranged from frequent yelling matches over power/control issues, to mothers' perception of their daughters' disrespectful attitudes or tones, to an unwillingness of clients to talk with mothers about meaningful aspects of their lives (thoughts, feelings, or events). This theme fits with the dominant discourse about adolescence as a time of increasing separation between parents and children. It also fits with the conflicts that arise in families at a time when parents internalize the dominant discourse of parental responsibility and need to control with respect to the type of adults their children are becoming (Zimmerman & Dickerson, 1996; Eron & Lund, 1996; Parry & Doan, 1994).

Grief/Loss Issues

Expressions of grief were common to all clients to some degree. One had recently lost her admiration for an older sister for whom she now had no respect, and with whom she frequently argued. Another had recently lost a long term foster placement and was wanting to resume living with her mother, a situation which had not yet materialized. Another one was grieving the loss of a father who had abandoned her and her mother when she was little. She compared her situation to that of a friend's two-parent family:

That's what makes me sad, like look at them compared to me. And like, what

would it feel like to have a dad? Like, look at their dad, he's there for them and mine isn't here, and mine is probably dead. (B:03, May 26/99)

Body Image Issues

With respect to body image, all but one seemed to be concerned about either being too fat now and/or being afraid of gaining any weight. Two of them did not directly express that concern during sessions, but their mothers stated that their daughters had told them about wanting to lose weight. One of those two had a brief history of self-induced vomiting. The one client without the fear of fat was one who worried about being anorexic because she had lost quite a bit of weight recently. This weight loss was found to be related to changes in her environment and activity level rather than to an eating disturbed behavior problem. On a positive note, all but the client with the most severe and long term problem(s) expressed an enjoyment of some kinds of sports or exercise activity that did not seem to be used as a method of purging.

Questionable Commitment To Therapy

It appeared that only two of the eight clients were truly interested in attending therapy rather than being motivated mainly by compliance to their parents' wishes. Those two clients seemed to have the lowest self-esteem level based on their poor self-evaluation in such areas as intellect and appearance. These clients also seemed to have the most insight into the nature of the problems they were facing, and had a history of positive experiences with therapists. Nevertheless, the reliability of their attendance depended largely on the ability and willingness of their parents to provide transportation. Thus the strong influence of parents on an adolescent's life makes it more difficult to

determine the adolescent's level of commitment to therapy. Also, an evaluation of motivation issues may be clouded by the fact that, in five of the cases, school classes (generally disliked by those clients) were being missed in order to attend therapy.

Themes of Change

This topic is divided into (a) progress in learning and practicing the theory and techniques of narrative therapy with adolescent female clients struggling with problems that include varying degrees of eating disturbed behavior, and (b) clients' progress in re-authoring their life stories.

Analysis of Practice

Practice of key elements of narrative therapy will be demonstrated by examples from session transcripts, and will be divided into the different phases for organizational purposes. The elements discussed include: Externalization, Collaboration with Client, Perspectives, Temporal Issues, Meaning Making, and Therapist Situation.

Construction of the Problem.

Was there collaboration with clients in naming the problem and exploring adequately the nature and effects of the problem?

Before exploring problem issues, a focus on getting to know clients outside of their problem-saturated stories, asking about "their interests, abilities, knowledge, and characteristics" (Freeman et al., 1997, p. 34), was vital in order to develop rapport and increase the comfort level of clients.

In naming the problem, the intention was to use words that best fit the client's experience of the problem, preferably using the client's own vocabulary. Examples of

problem names included "emptiness" (Client B), "the not good enough attitude" (Client C), "the fat problem", (Client G), "fear" (Client H), "anger/sadness" (Client D). With the other three clients, "the problem" was the most frequently used name. Client F, who had just one session, used the words "guilt" and "fear" with respect to eating and weight. The other two, clients A and E, whose problem foci were fighting with sisters and family relationships respectively, viewed other people in their lives as the problems, and the problem name most used with them was "anger". Those clients who had been involved in previous therapy were more apt to use clinical words like "depression", (B, C, H), "anorexia" and "bulimia" (H).

Initially, there was concern about coming up with the one "perfect" name that would reflect the client's entire experience. That concern faded with the realization that it was acceptable to call it "the problem" until a better problem name that more fully connoted the client's experience was found (Zimmerman & Dickerson, 1996). As well, it was acceptable to have different names for the problem relevant to the particular discussion at hand or the complexity of the issues. The use of externalizing conversation is considered more important than quick reduction to one particular problem name, which can restrict the ability to fully explore the client's experience (McKenzie & Monk, 1997). For example, one client had several major problems including anxiety, depression, and bulimia. It took several sessions to decide which problem was the most salient (anxiety), and which problems were of a secondary nature. When initially asked to name the most pressing problem, her response was, "I don't know. There's lots of things. Like I have a huge problem with change" (H:01, July 20/99). Subsequent discussion of that problem

included talking about that problem's effects on the other problems.

An initial experience of awkwardness in helping the client come up with a name for the problem was partly due to adherence to traditional, less collaborative orientations that focus more on the importance of what the therapist perceives as the problem. Increasing ease with implementing this practice was accompanied by greater skill in making the process clearer and easier for the client to understand. For example, in an earlier session a question asked was "How do you view the problem? Do you have a name for it?. . . Sometimes it helps to look at the effects of the problem to be able to understand . . . get a better idea of what the problem is" (F:01, April 23/99). During a later session with another client the question was "Have you got a name for the problem? If you were going to say, this is the problem I'm facing, this is the problem I'm dealing with, what would you call it? Do you have a few words or a phrase?" (H:01, July 20/99).

Awkwardness in naming the problem was reflected by a tendency to explain the approach to clients, and to ask them if they were okay with it. For example, "The way that I view things is I don't see problems as being in people or in relationships . . . I see it as something that's outside of people, and the effects of this problem get you to do things . . . that are harmful to yourself" (D:01, April 30/99). This tendency for explanation was validated by McKenzie and Monk (1997), who stated that initial awkwardness seems to be common for therapists new to the externalization process, and a legitimate method of dealing with that awkwardness is for therapists to explain the process.

Exploring effects of the problem on clients' behaviors, thoughts, and feelings, not only helped in finding a name for the problem, but was also a good method of acquiring

information about how clients interact with the various systems in their lives, and how they perceive that other people view them. As many different aspects of clients' lives as possible were brought into the discussion, with a focus on clients' relationships with themselves, as well as with other people such as families, friends, teachers, and the outside world (Zimmerman & Dickerson, 1996).

During the problem construction phase of therapy, other people's perspectives were brought into the therapy sessions in a number of ways. In some cases, parents' involvement in first sessions provided the first opportunity for parent and child to openly acknowledge or discuss a problem issue, and allowed clients to better understand how their parents viewed the nature of the problem and were affected by the problem. It also provided an opportunity for the therapist to witness how the problem affected the relationship between parent and child.

It can be beneficial for clients to understand the history of how the problem came to influence them, i.e., what made them vulnerable to its ploys (Eron & Lund, 1996; Parry & Doan, 1994). Looking at the various narratives affecting them in the past helps to relieve some of the feeling that their own lacks or defects of personality made it possible for the problem to take over their lives. One client described how the problem's influence on her eating behavior gradually increased over time after she became a vegetarian, lost weight, became more nutrition conscious, started writing down the number of calories she was eating, and "started going down in calories more and more" (H:03, August 5/99).

Griffith and Griffith (1994) point out the importance of helping clients to be aware of the significance of the problem in their lives--remembering how different things

were prior to the problem's emergence; how over time they have grown more accepting and less sensitive to the magnitude of the daily effects of the problem; and how they have not fully realized the long term consequences of these cumulative experiences (p. 116). Speculating on what the effects of the problem will be in the future if nothing changes can help motivate clients toward making changes (McKenzie & Monk, 1997). One client complained about her younger brother graduating from high school before her. Asking her "What parts of being a teenager are you missing out on?" allowed her to talk about the bitterness she would feel on missing out on the enjoyment of typical teenage activities (H:05, August 19/99).

Exploring effects of the problem could be an upsetting phase because it is so negatively focused, so it is important to use the externalization process here as much as possible, and also to ensure that historical and short term "positive" effects of the problem are adequately covered. One client described one of the effects of bulimia on her life. When asked "If the fat problem wasn't in your life . . . what would be different in your life?, she replied, "I'd have more time to do the things I like to do. I wouldn't always be thinking about it" (G:05, August 10/99). At the same time she talked about how difficult it was to avoid purging because it brought her such "relief". Another client talked about the emptiness and sadness affecting her grades by making it hard for her to concentrate "because I always think about . . . . what's wrong inside of me" (B:01, May 12/99).

Perhaps more attention should have been paid in this practicum to effects of the problem, which may not have been explored adequately due to the unintentional choice to dwell on more pleasant positive change issues such as unique outcomes or preferred

stories.

Deconstruction.

Did the therapist help clients to: look at and question the taken for granted assumptions/beliefs/values that support problem stories; to see that there are different ways of looking at the same thing; and to realize that just because they think or feel a certain way does not mean that way is a "truth" about themselves, that they are that way and will always be that way?

Personification of the problem as a separate entity, thing, or person that is an "active agent" (Zimerman & Dickerson, 1996, p. 303) in the client's life allows discussion of the problem's "intentions", "beliefs", and "practices" (Epston et al., 1995, p. 74). Deconstructive questioning involves a focus on the "problematic beliefs, practices, feelings, and attitudes" that support or derive from the narratives (Freedman & Combs, 1996, p. 120). Those beliefs, practices, feelings, and attitudes are addressed within such aspects as the history of the client's relationship with them, the context affecting them, their effects on the client's life, their interrelationships with each other, and their "tactics or strategies" (Freedman & Combs, p. 121).

Examining the effects of the problem provides an opportunity to deconstruct the problem. By objectively exploring how clients habitually react to the problem's influence, it becomes more clear as to what kinds of client behaviors would not promote the problem's intentions. One client was encouraged to do some "spying on the problem" (White & Epston, 1990) to learn more about how it influences her (G:01, June 8/99).

In the following example, some of the tactics used by the "not good enough

attitude" are explored by asking what is said by "the voice that puts you down". The client replies with "it just mentions all like whatever I did that made me feel bad. It . . . says . . . 'That was so dumb. Like why do you do that?'" (C:05, April 23/99).

One aspect of the deconstructive process is its move from questions geared more toward listening and understanding stories, to questions of a more directly deconstructive nature. With respect to the deconstructive listening process, "Most of this process occurs automatically and subliminally as a result of our beliefs about narrative and social constructionism. It is not a didactic or intellectual process . . . we strive to listen closely and carefully with an attitude that is solidly grounded in these notions" (Combs & Freedman, 1994, p. 72). As someone learning narrative therapy, it was difficult to evaluate the ability to listen in a deconstructive manner, since that is something that seems to be more a natural, instinctive practice that comes with the appropriate attitude.

The more interventive deconstructive questions "invite people to see their stories from a different perspective, to notice how they are constructed (or that they are constructed), to note their limits, or to discover that there are possible narratives" (Combs & Freedman, 1994, p. 72). It is difficult to tell whether talking about and questioning cultural ideals, such as women needing to be thin, had much effect on helping clients to change their behaviors. For example, there was the statement to one client that "you look in magazines and you see all these skinny models and things and you think oh no. I should look like that . . . And it's real hard on young women to sort of love themselves and how they look and accept themselves as they are" (A:01, July 5/99). The two clients with the greater history of eating disturbed behavior had done some reading and were

aware of how society's thinness ideals for women were affecting them. It may have been helpful to more fully explore with them the effects of this discourse on their lives, and how it was connected to their own experiences.

There was an attempt to create a context in which a mother could change the narratives about the parental role. She talked about the guilt she felt about her daughter's eating disturbed behavior, stating "What am I doing wrong as a parent? You feel guilty about anything you view as a problem." The idea was pointed out to her that "Lots of times it's a bit of a myth that parents are responsible for everything kids do or everything that happens" (F:01, April 23 /99).

The two latter examples demonstrate how highly influenced the therapist can be by previous learning about psychological theories and the need to fulfill the role as expert. There was frequent use of "interpretive, diagnostic or interventive statements" (Combs & Freedman,1994, p.70). Although the goal was to use questioning and the "not knowing attitude", this can be difficult when "dominant stories in Western culture still value decisiveness, action, and certitude" (Combs & Freedman, p. 71). Smith (1997) describes being tempted "to become immersed in my own assumptions about what the client means, and I often experience a sense of urgency to 'make' things happen" (p. 43).

With one client there was an attempt to help her understand that food deprivation contributes to bingeing, and that eating regular meals can be helpful in breaking the binge/purge cycle. But instead of using questions to explore her experience with this idea, direct intervention was used to give her that advice in a declarative manner.

Unique Outcomes.

Did the therapist make clients aware of unique outcomes and ask if those outcomes were preferred?

Usually clients have been able to acknowledge from the first session that there are some situations in which the problem is not there. For example, most talked about the problem dissipating when they participated in sports they enjoyed and spent time with friends. All clients were asked at various times whether discussions focused on what they wanted to discuss, and whether there were any changes they'd like to make in the therapy process. They were also invited to set the direction of conversation at the beginning of sessions. For example, a question asked was "How would you like to start today?Would you like me to review what we talked about last time, or just start talking about how things have gone this last week?" (C:05, April 23/99). Allowing them to make decisions about the therapy process helped to create a context of collaboration while providing them with opportunities to demonstrate assertiveness within the therapy sessions.

It has been helpful having mothers attend some sessions, as they have been able to point out positives about their daughters that the clients themselves did not mention. The clients' higher nervousness level and lower sense of power, especially in the initial therapy session, are understandable for such possible reasons as their position as "child" being asked questions by an adult, the novelty of the interview process, and the clients' possibly negative view that they are coming to therapy because they are defective in some way. One mother described the last time she saw her daughter in an anti-depression mode: "I think the last time I ever saw her animated was at a hockey game . . . her brother

was playing in a final . . . . and she was just screaming" (H:06, Sept. 2/99).

Thickening Preferred Stories.

Did the therapist facilitate thickening of preferred stories by: 1) ensuring that in the client's view the story was indeed preferred, 2) pointing out reduction of the problem's influence on the client's life, 3) exploring both the landscape of action (details of events and client's actions) and the landscape of consciousness (significance or meaning of those events and actions), 4) bringing other people into the therapy process to provide witness/audience to the preferred stories, and 5) exploring preferred stories in past, present, and future modalities?

1. If a particular unique outcome is not valued by the client, the therapist does not incorporate that outcome within the client's preferred story. Further collaboration with the client is demonstrated by checking to ensure that the unfolding alternative stories are indeed the client's preferred alternatives to the problem-saturated stories. Asking the client whether she prefers the new story that is emerging is vital to ensuring that the client and not the therapist is leading the direction of change.

2. Pointing out both reductions in the amount of time or severity of the problem's influence on clients' lives, as well as complete absences of the problem's influence, are ways of building up preferred stories within externalizing conversation. An example of using externalization to draw out a contradiction to the problem-saturated story involved asking a client if there were "other times that your problem isn't there . . . when you're at home, are some times better than other times?" She stated that "Some days I can control it if I just want to read or something" (G:01, June 8/99).

Externalization of the problem allows an examination of the relative influence of the problem in a person's life. Asking clients what proportion of time the problem influences them allows a way to evaluate how much of the time they themselves are influencing or controlling the problem. This type of question was used a couple of times during the practicum in the early stages of therapy. One client readily responded with "probably 60-70%" when asked "whether it's something that takes up 50% of your time, worrying about this, or 80% or 20%, or whatever" (G:01, June 8/99). When asked the same question in the fourth session, during which she said purging incidents had decreased, she said "I don't know."

3. The following example demonstrates an attempt to explore how the client has been able to create, within the landscape of consciousness, the preferred event of starting to talk and associate with a new group of people she was previously too fearful to approach. To summon the courage to do that, the client said she told herself that it would be good practice for her to socialize with people she didn't know well because next year she would attend a new school where she knew no one.

In general, with all clients, it was much easier for them to talk about negative events in their lives, rather than to discuss details of positive occurrences. It might have been helpful to ask more questions to open up the discussion of preferred events--the how's, why's, where's, when's, what's and who's of favorable incidents. In the case of one client, it had been difficult getting details about preferred events, and she seemed to be giving herself little credit for making these events happen. For example, she attributed positive changes in her social life at school to the influence of a recently renewed

relationship with her one close friend who introduced her to a new, preferred group of friends. At one point she seemed to accept credit for her own initiative in taking advantage of this social opportunity. However, she later started to believe the negative statements of her sister, who told her the new people she was meeting did not like her, and only talked to her because she was the friend of someone they did like. That issue was addressed by having the sister attend one session and tell the client that she did not actually believe that disparaging remark to be true.

An example of exploring the landscape of action with one client included pointing out ways of avoiding bulimic behavior, such as planning social events ahead of time: "So you've got that to look forward to and you know you don't want to make yourself feel sick?" She agreed that was an "anti-problem" tactic that she could use more often (G:03, July 15/99). It was more difficult to draw out the landscape of consciousness in finding out what clients' preferred actions meant to them or revealed about themselves, their beliefs, values, or attributes. This fits with the concept of adolescents being less familiar with dealing in abstracts. It also indicates that the wording of questions may have been a problem. Using a more abstract version such as "What does that mean to you?" would be less effective than using one that incorporated more concrete details, such as "Does being able to make new friends on your own tell you something about yourself that you didn't know before?"

4. It is useful to ask clients who else has noticed the unfolding of preferred stories, what those people have said about the clients, and whether clients have noticed changes in other people's behavior toward them. Having mothers attend middle and later sessions

provides clients with an audience to preferred stories and with witnesses who can provide accounts of those stories revealed outside the therapy session. At a middle session, one mother stated that her daughter had "been more responsible, going and doing her things, and just happier and . . . has changed her attitude towards other people . . . teachers and things" (C:06, May 7/99).

5. Discussion of preferred realities within past, present, and future modalities builds a counterplot to the problem story, allowing clients to view themselves in positions of strength along a continuous time line. It is helpful to ask clients to envision themselves in the future according to their dreams and wishes about their preferred realities. This provides hopefulness and an opportunity for them to experience themselves (albeit in a temporary state of imagining) as the persons they want to be, doing what they want to do. This also provides a glimpse into the depth of their depression or low self-esteem if they are unable to provide any ideas about what they would like to have in their lives, rather than simply what it is they want to escape.

One client, facing a fear problem, talked about what she'd be doing if the problem wasn't there. As part of her response to the "miracle question" (de Shazer, 1985), asking her what her life would be like "in an ideal world, if you woke up one morning and everything had changed so that your life was the way you wanted it to be?", she stated that "if I didn't have the fear of change, or leaving mom or leaving my house or of like totally messing things up . . . like if I was totally independent and fearless, I would probably want to pick up and move down to California and go be an actress" (H:01, July 20/99).

Client Progress (see Tables 4 through 11)

With respect to client progress, the focus of change in narrative therapy is changing narratives. It is the client's experience and not the therapist's opinion that is crucial. Analysis is based on what the client says and does, and what the therapist observes during interviews. The following aspects of clients' lives are explored with respect to whether change occurred: peer relationships, relationship with mother, mood, school issues, and problem focus reduction. These themes were chosen based on the same data analysis techniques used to develop client themes and practice evaluation elements. Relationship with father is not included because only mothers were directly involved in the therapy process.

By the end of therapy sessions, there had been some progress for all clients with respect to reduction in the problem foci they had chosen to address during first sessions. (This does not include one client who did not return after the first session, claiming at that time that the problem had recently been diminishing, and that she was unsure whether therapy was necessary.) The evidence of positive change in other areas was to some extent related to the number of sessions attended, with the most progress for the client seen for 12 sessions, and the least progress for the client attending three sessions.

With respect to progress from session to session, all but one client showed improvement in at least one theme during the second session. This may have been related to any of a number of factors, such as engagement during the first session; effect of mother's presence during the first session; or changes in environmental factors outside sessions. At the third session all demonstrated the same or worse condition in themes,

Table 4

Client Progress From First To Last Session

Client	Peer relation-ships	Relationship with mother	Mood	Number of sessions	School issues	Problem focus
A				3		X
B	X		X	7	X	X
C	X	X	X	12	X	X
D				5	X	X
E			X	5		X
F				1		
G		X	X	8		X
H	X	X		6	X	X

with only one client also demonstrating a better situation in four of the six theme areas. The fourth and fifth sessions displayed more variation among clients. The four people who attended sixth sessions all revealed either same or better conditions. The three clients at the seventh sessions demonstrated mainly the same situations, with one having some better indicators as well. The client with a total of eight sessions showed progress in the eighth session.

Client A (see Table 5)

A was somewhat coerced into attending therapy sessions with her mother, who bribed her into attending the first two sessions, and simply told her at home that she had to attend the third one. At the first session, mother spent a lot of time talking about her concerns about her other daughters, for whom she also wanted therapy. At the second session A stated that she had been fighting less with her sisters and spending more time with friends since the first session. Also, the family had discussed together some of the concerns addressed at the first session regarding verbal and possible physical abuse among the sisters. An attempt to refer the family for family therapy was met with mother's request that at least one more session be conducted with her and A to focus on the eating/weight issue that was a source of conflict between the two of them. At the third session it became evident that eating/weight was much more of a problem for mother than for her daughter; and mother finally accepted A's refusal to attend a fourth session.

Client B (see Table 6)

For B, things began going much better for her soon after sessions started. In fact after seven sessions, her mother was concerned about her having too much of an active

Table 5

A's Progress By Session

Session 1	Self-esteem	Peer relation-ships	Relation-ship with mother	Mood	School	Problem focus
Session 2			X			X
Session 3						

Note. Problem focus = Anger/Fighting with sisters.

Table 6

B's Progress By Session

Session 1	Self-esteem	Peer relation-ships	Relation-ship with mother	Mood	School	Problem focus
Session 2	X	X	X	X	X	X
Session 3						
Session 4						
Session 5						
Session 6	X					
Session 7						

Note. Problem focus = emptiness/sadness.

social life and of not being compliant enough regarding mother's expectations. Mother's original concern in bringing her daughter to therapy was that she was depressed, had low self-esteem, and was staying home and crying in her room a lot. By the end of the practicum, B complained mainly about her mother's behavior. At a follow-up meeting with her and her mother, B stated that she was "not depressed" and did not want to attend any further therapy. Her mother believed that B did need therapy because of a recent bout of sadness and self-deprecation. B believed that her mother was over-reacting due to having stopped taking her own anti-depressant medication a month earlier. Fortunately, mother had put herself on the waiting list for parenting and/or family therapy at another agency.

Client C (see Table 7)

C attended 12 sessions (plus one psychiatric assessment), stating at the last session that she was "not depressed" and saw no need for further sessions. She was in a positive mood during that session, which was linked to having started summer vacation. A few months later her mother reported, in a follow up phone conversation, that C had been in good spirits during the summer, was attending a new school where she was functioning well, and did not want or need any further therapy at that time. With other changes in her life such as a new school environment and the medication she began taking after termination, it is difficult to determine the degree to which her progress can be attributed to therapy sessions. However, from the beginning of therapy she expressed that she liked having the opportunity to talk at sessions about what was bothering her, and that this alone was therapeutic.

Table 7

C's Progress By Session

Session 1	Self-esteem	Peer relation-ships	Relation-ship with mother	Mood	School	Problem Focus
Session 2				X		
Session 3						
Session 4	X	X		X	X	
Session 5		X		X		X
Session 6	X	X	X	X	X	X
Session 7						
Session 8						
Session 9						
Session 10						
Session 11						
Session 12	X	X	X	X		X

Note. Problem focus = Sadness/Not good enough attitude.

Client D (see Table 8)

D seemed to be attending therapy mainly to comply with her mother's wishes. In a phone conversation prior to the fifth session, her mother claimed that D was "happy", "content", and "doesn't lose it" on the days she attends sessions. Although initially determined by mother and daughter that it was at school where the anger problem was most problematic, it became evident that "temper fits" were much more common at home than at school, where, according to a school therapist, D was not considered to have a major behavior problem. That therapist also said that she had a difficult time talking with D during their past sessions together, attributing this in part to D's verbal and intellectual delays.

During the fifth and last session D stated that she was working harder and having fewer anger attacks at school. She also talked more openly about family issues, saying that her mother had assured her that it was okay to do that, and that the content of therapy sessions had been kept confidential from mother. Her mother was scheduled to attend the next session with D in order to deal with major issues regarding mother's behaviors and beliefs affecting D. This may have contributed to the fifth session unexpectedly being the final one. There were several non-attended or cancelled sessions. School had ended when mother called to state that D wanted to spend time with her friends and to attend therapy only at the spur of the moment when it suited her.

Client E (see Table 9)

E seemed to enjoy talking about her life. However, she was not interested in working on making changes in her life, and stated that if she was living with her

Table 8

D's Progress By Session

Session 1	Self-esteem	Peer Relation-ships	Relation-ship with mother	Mood	School	Problem Focus
Session 2				X		X
Session 3						
Session 4						
Session 5	X			X	X	X

Note. Problem focus = Anger.

Table 9

E's Progress By Session

Session 1	Self-esteem	Peer relation-ships	Relation-ship with mother	Mood	School	Problem focus
Session 2			X			
Session 3	X		X	X		X
Session 4			X	X		
Session 5						

Note. Problem focus = Anger/Family relationships.

biological mother, she'd be able to talk to her and wouldn't need therapy. Initially she agreed to attend therapy because she thought it would facilitate her being able to move from a foster home into her biological mother's home. During the second session she was tired and in a very negative mood. The session was cut short, and she was offered a drive to school. During the drive she perked up a bit in the car, and asked to meet at a fast food restaurant for the next session. That next session and the two that followed took place at the restaurant, and were requested by her on a sporadic basis. During sessions she went from liking her new foster parent to disliking her and stating her belief that she would be returning to her mother's home by September. She was expelled from school due to a lack of attendance, which did not seem to bother her. Her mood at all but the second session was quite positive as she smiled frequently and was talkative.

Client G (see Table 10)

From the beginning of involvement, G seemed to be functioning well in all aspects of her life except eating issues. That may have affected her commitment to therapy. She may not have viewed the bulimic behavior as negatively affecting other aspects of her life enough for her to be adequately motivated to work on change. During sessions she stated that frequency of the eating disturbed behaviors had decreased. It is difficult to determine whether she actually perceived a difference, or was saying this to please the therapist. At the end of the practicum, she decided to discontinue seeing the physician she'd seen a few times, and also decided not to attend the treatment program at the Health Sciences Eating Disorder Clinic. She said she felt she could deal with the problem on her own.

Table 10

G's Progress By Session

Session 1	Self-esteem	Peer Relation-ships	Relation-ship with mother	Mood	School	Problem Focus
Session 2	X			X		X
Session 3						
Session 4	X			X		X
Session 5						
Session 6						
Session 7	X		X	X		
Session 8	X			X	X	

Note. Problem focus = the fat problem.

It may have been beneficial to spend more time exploring her life outside the eating issue and how all aspects were affected by the eating disturbed behavior. The main problem for her seemed to be the fact that her parents were worried about her and keeping surveillance on her. Her motivation to attend therapy involved her concern about having started using laxatives in addition to self-induced vomiting, because it was easier to hide the laxative type of purging from her parents. However, she refused to discuss the eating issue with her mother in the room. The fact that she would soon leave her parents' home to live elsewhere may have affected her desire to work on the eating disturbed behavior as well as relationship problems with her parents. She denied that there were any family problems.

Client H (see Table 11)

H had participated in previous therapy focusing on the eating disturbed behavior issue. That issue appeared to be secondary to others in her life, as her functioning was severely affected by an anxiety or "fear" problem. She believed that her current focus on menu planning and eating would fade away as she started to engage in other activities that she found enjoyable. A turning point for her was the beginning of the school year in September, and her decision to attend one class twice a week which she began around the time of the last session. She was also hopeful about the potential benefit of anti-depressant medication recently prescribed by her physician. Her mother was very committed to supporting her daughter's attempts to deal with the fear problem. After the practicum ended, H continued under that physician's care and began family work with another therapist at the practicum setting.

Table 11

H's Progress By Session

Session 1	Self-esteem	Peer relation-ships	Relation-ship with mother	Mood	School	Problem Focus
Session 2						
Session 3						
Session 4						
Session 5						
Session 6		X	X		X	X

Note. Problem focus = Fear.

CHAPTER 5

Conclusions

This practicum has been successful in providing a valuable learning opportunity in the endeavour to implement the narrative therapy approach with female adolescents with varying degrees of eating disturbed behavior. The following thoughts and ideas emerged from this practicum experience.

Narrative Therapy

The practice of narrative therapy can be intrinsically rewarding for the therapist due to its focus on exploring clients' strengths and positive changes within the context of externalizing conversation. For therapists, "Focusing our attention on values, hopes, and preferences in relation to problems, rather than on pathology, we find ourselves less fatigued by the weight of the difficulties we encounter" (Freeman et al., 1997, p. 11). There is the effect of externalizing language on relieving some of the pathological weight on the client. It seemed to lighten the sessions and increase the positiveness and initiative of the client to talk about and explore the nature of the problem and its effects on her life. Client and therapist could be more equal collaborators fighting against an entity, rather than against the client's experience of herself. Her feelings and thoughts were validated as appropriate responses to the tactics and general influence of the problem. She was viewed as a strong, whole person, intact and equipped to deal with whatever problem she was facing.

Therapist self-knowledge is vital to her/his ability to view and discuss problems in an externalized manner as the effectiveness of this approach is hindered by the therapist

having unwittingly adopted certain dominant discourses about human behavior that conflict with the narrative point of view. One example of such a dominant discourse is the idea that people have problem personalities which are very difficult and time consuming to change. Madigan (1998) states that "if a therapist does not situate and recognize the community's influence in problem making, the sociopolitical and cultural thrust of externalizing practices might be lost, and their experience of externalizing therapeutic conversations would be cursory" (p. 89).

According to the literature, the more fully the therapist can embrace the heart/spirit/attitude of this approach toward clients and problems, the more naturally the techniques end up being used. For example, " . . . when people approach externalization as a technique or a linguistic trick, it can come off as shallow, forced, and not especially helpful" (Freedman & Combs, 1996, p. 47). That may be indicative of a problem encountered in this practicum--the therapist's "trying too hard" attitude, rather than incorporating techniques as they naturally seem to fit within the particular therapy session.

Concern about using the approach properly and thinking about what question to ask next, made it difficult to focus on clients and their experiences. Smith (1997, p. 43) talks about his own coping with such issues by an "attempt to attune myself to the client" --"to notice changes in the client's tone of voice, emphasis, physical posture, and the like as guides for discerning what the client seems most moved by in each utterance." The attempt to do that in this practicum resulted in often working outside the narrative style by not using externalizing conversation about the problem.

The facilitation of externalizing conversations was difficult to learn. It is uncertain how much of this was a result of the therapist requiring more practice or an attitude change, and how much was the result of this style not fitting for clients. O'Hanlon (1994) states that he uses externalization of the problem only with people who "have organized their identity around the problem", as "not everybody needs an identity overhaul, and most people I see just come in for simple problem solving; their concerns have not become life-encompassing or defining" (p. 28). Perhaps part of the reason externalization didn't seem to fit well for some of the practicum clients was because they were affected less severely by the problems. The benefits of talking about an external problem could be more readily noticed with clients who felt more consumed by the problem. Coincidentally, they were also the ones for whom eating disturbed behavior was more encompassing in their lives.

Newer therapists may have greater difficulty learning this approach as compared to other therapy approaches, since there is so much dependence on the therapist's ability to tune into each particular client and to use a combination of intuition, talent, knowledge, and experience. All therapy incorporates clients' stories to some extent, so what makes narrative therapy distinct from other approaches (besides externalization) can seem quite intangible. If clients don't naturally talk in the manner of abstracting and objectifying beliefs, feelings, attitudes etc., striving to have them do so seems to contradict the basic premise of narrative therapy, which is to collaborate with clients as much as possible, honouring their experience or view of the world.

On that note, there is the question about the value of this viewpoint for clients

who want the therapist to "fix" them by giving them advice or direct suggestions as to directions to take in their lives. An important aspect of narrative therapy is its focus on clients' sense of their own power in dealing with problems. Thus, if clients leave therapy with the belief that therapists are more responsible then themselves for the creation of positive changes in their lives, their self-confidence is diminished in that they come to rely on an external influence for direction rather than listen to their own voices (Freedman & Combs, 1996).

However, based on the importance of collaboration with clients, it would seem that if clients want advice or educational information, therapists ought to provide that. It may be helpful to give clients information (verbal and/or written; theory and/or fact) that would allow them to have a broader knowledge base, so that client and therapist could both collaborate more equally on dealing with issues. That does not mean that they would need to accept that information as true for them. But it might broaden their perspectives and better allow them to solve their own problems.

One drawback in focusing on the narrative therapy approach involves responding to clients who want to understand why the problem behaviors occur. Partly because narrative therapy is much less linear or causal in its approach, it can be more difficult to explain behavior to clients in narrative therapy terms (i.e., that people do what they do because of the influence of stories held as truths by society, themselves, and other people; and that each person's behavior is based on a constant, mutual, back-and-forth process of interaction of their own and others' actions, responses, and meanings given to events). It seemed helpful in this practicum to draw on other theories of human behavior such as

behaviorist or cognitive ideas to discuss particular behavior occurrences.

Advocating the use of medication for two practicum clients could be construed as an anti-narrative strategy. If problems are socially, culturally, and politically created, how does this viewpoint accommodate the use of medication, a practice which assumes there to be an internal biological problem within the person's individual physical being? However, in certain situations and with certain guidelines, supporting the use of medication seems appropriate: if there are physical problems such as sleep, appetite, and energy difficulties; if the person is well informed about the proposed medication and its possible effects; if she has voluntarily chosen to take the medication; if the severity or chronicity of the problem warrants it; and if she knows that medication therapy alone is usually not enough, but is rather one of many tools that can help her carry out the actions she needs to take in fighting the problem (Raymond, Mitchell, Fallon, & Katzman, 1994). As described by a narrative therapy oriented psychiatrist suggesting anti-depressant medication to a client, " . . . people are made up of biochemicals as well as hopes, wishes, thoughts, feelings, and spirits . . . Do you think it might be worth us considering how to fight depression at the biochemical level as well?" (Simblett, 1997, p 145).

Adolescence

Practicum findings generally concurred with the literature on adolescents with respect to the salience of such themes as body image, separation from parents, therapy, and self-esteem issues which are strongly affected by the sense of how much control adolescents perceive themselves having over their lives.

Determining the adolescent's degree of commitment to therapy is vital. Narrative

therapy geared toward individual work with adolescents may not be effective if clients attend more in order to comply with parents' wishes than to improve their own lives. If the mother is more concerned about a problem than the client, the mother and the adolescent should be seen together. The three clients who seemed the most committed to therapy were more talkative during sessions and more interested in telling their stories.

Thus the lack of commitment to therapy corresponded with practicum clients who seemed less at ease with talking during therapy sessions, and tended to look more to the therapist to initiate conversation topics, and to keep them talking. They seemed somewhat passive in the therapy situation. To some extent that seemed to fit for most of the clients, and is likely due in part to their being accustomed to having less of a sense of personal agency in comparison to adults who hold such control and power over their daily lives.

Entering the world of adolescents and developing a rapport is easier when it is on their terms of where they want to meet, rather than in the office. This gives them more control, and reduces the attitude that therapy is something else they know little about that is imposed on them by adults "for their own good". For example, one client seemed especially talkative and open about her life at the three sessions which were held at a fast food restaurant on a sporadic basis, at her request, rather than every week.

The problem of conducting therapy with adolescents who are less verbally expressive of their thoughts and feelings, and less inclined to disclose to adult authority figures, could have been addressed by incorporating activities or non-talking means of communication, such as visualization, drawing, or writing exercises during therapy sessions. One client was encouraged to bring in a sample of her poetry. There was some

discussion about her writings during therapy sessions. More of a therapy focus on her writing and the images and metaphors that emerged from it would have been beneficial.

There were attempts to have clients do "homework" between sessions. For example, one was encouraged to write down her feelings and thoughts before and/or after bingeing or purging episodes. Another client was encouraged to put together a collage of images cut from magazine pictures depicting aspects of her preferred story. One was given a list of anger management steps to carry with her to remind her how to prevent anger from taking control of her behavior. Clients did not follow through with these suggestions. A better strategy would have been to have clients involved in activities with the therapist during the therapy sessions. Drawing genograms during sessions may have been more beneficial than simply collecting verbal information about family background.

Every case pointed toward the need for more family work, whether for the purpose of providing details of history unknown or forgotten by the client; for the purpose of dealing with family relationship issues that seemed to affect the client's day to day functioning and sense of identity; or simply to allow communication between parent and child that would allow each to better understand the other's perspective and intentions underlying behavior. The involvement of other family members allows a greater number of perspectives on the problem to emerge, and offers a greater opportunity for audience/witness to preferred stories.

It may have been useful to see mothers and daughters separately for first sessions before meeting with them together. Inclusion of mothers in first sessions tended to result in mothers doing most of the talking, and less of an opportunity for the therapist to

engage with clients and determine their own commitment to therapy. In first/earlier sessions with clients alone, engagement went well. Clients seemed talkative and readily told their stories when it came to the histories of their lives or the problems with which they were struggling. This may be related to therapist focus on exploring positive aspects of their lives and actively listening and asking questions about topics that seemed most interesting to them. The degree to which they would open up about family issues seemed related in part to how much they trusted that conversations would be kept confidential and not revealed to parents. One client began talking about family issues after her mother told her that the therapist had not revealed to her the content of sessions so far, and that she wanted her daughter to be open with the therapist about the family situation.

It is interesting to note that fathers tended to be viewed by clients as either negative influences or absent (physically and/or emotionally) figures in clients' lives. They did not have direct involvement in the therapy process, due mainly to clients' preferences. All clients expressed feeling closer to their mothers than their fathers. One client visited her birth father on a regular basis, but did not feel close to him. She also strongly disliked her stepfather. Another client visited her birth father sporadically, and struggled with his pleas for her to leave her mother and move in with him and his current wife. Two wanted no contact with their birth fathers, whom they had not seen in several years, and about whom they expressed only negative feelings.

It was assumed on beginning the practicum that the use of metaphors would be helpful in dealing with adolescent clients, as they promote a broadening of perspectives. Since metaphors contain a broad scope of meanings or meaning levels that can be

ascribed to a word or phrase, they allow clients to more fully use their own experience and perspective to fit an idea into their lives. Thus clients would not be as reliant on the therapist to verbally encompass their experiences. This would seem to be especially beneficial in working with adolescents, since the world view of an adult therapist tends to be quite different from that of an adolescent client. However, transcripts of sessions revealed little use of metaphors by clients, except when one person, at the therapist's request, brought in a sample of her poetry. She wrote about bulimia and its "voices" making her "a prisoner of my own body", and referred to the "poison of reality" where "skeletons on the runway" reflect a society in which "starvation is perfection" and "self-control is everything." (G:05, August 10/99).

At the same time, there is the question of whether the use of metaphors for clients who think in more concrete terms would cause confusion rather than benefit for the client. One metaphor that was used frequently was the idea of "fighting" the problem. The literature on narrative therapy with eating disturbed behavior problems tends to promote the use of militant, adversarial language by therapists (Epston et al., 1995). Parry and Doan (1994) emphasize the importance of the metaphor fitting the client, and describe the use of alternatives to the "battle" metaphor, with respect to all kinds of problems. They give the example of looking at the "gifts and lessons the old story has to offer, instead of coming up with counterstrategies to 'combat' the Old story. After the lessons that need learning have been identified, the therapy can center around what a re-visioned story will look like once this has happened." (p. 55).

Both "battle" and "lesson" type metaphors were used at different times with all

practicum clients. The "battle" metaphor was used more often because it seemed to fit better with the idea of externalizing the problem and empowering the client. For example, there was the question "How do you fight that voice . . . that's telling you whatever you do, it's gonna be dumb?" (C:05, April 23/99). There is a sense of energy and personal agency embodied in confronting an external force on a concrete level. The "lesson" type metaphor may fit better for clients who are more hesitant about their commitment to change. Also, it may be more relevant for adolescent females, who tend to be more empathic and relationship oriented, and less aggressively competitive (Gilligan, 1982).

Eating Disturbed Behavior

Client themes that emerged in this practicum were similar to those in the literature on eating disturbed behavior. Zimmerman and Dickerson (1994) mention the themes of self-criticism, perfectionism, self-surveillance, and "a shaping cultural discourse" (p. 296) within which women with eating problems come to know themselves through the "specifications set by the culture (e.g., women and thinness" (p. 295) rather than "through what [their] own experience tells [them] to value" (p. 295). Varying degrees of isolation and loneliness were expressed as resulting from clients attempting to keep the eating problem secret from friends and/or family.

Narrative therapy is an excellent approach to dealing with eating disturbed behavior because it focuses so strongly on issues of control/power in the relationship between therapist and client, and in all aspects of the therapy process. In corroboration with the literature, the need to gain control or power was a central theme for clients struggling with this problem. Also, narrative therapy allows the opportunity to focus on

issues other than the directly eating related ones which generally reflect the presence of other concerns. Dealing with those other concerns can loosen the hold that the eating disturbed behaviors have over people's lives. Eating disturbed behavior may be like the tip of the iceberg, and attempting to work directly on the eating without first or simultaneously exploring other problems, did not seem useful. Clients were asked what they most desired to focus on--emotional issues or the eating behaviors themselves. One said she wanted to work on both at the same time. The other said that she thought the behaviors would decrease if the other issues in her life were dealt with first.

Working with clients with eating disturbed behavior can have distinct effects on the therapist. The more out of control the clients feel, the more the therapist may feel the need to be in control. This points out the social constructionist belief that the therapist and not just the client is affected and changed by what happens in therapy sessions. Especially when dealing with clients with bulimic behaviors, there was a sense of urgency to hurry up and get these clients to stop doing their self-destructive behaviors. If they had not had recent medical check-ups, there was strong concern about their physical health. At times during the practicum, the idea of using a very structured approach seemed appealing. For example, Fairburn's treatment manual for bulimia sets out a step by step method with particular issues covered at particular times and particular "homework" given to clients at particular times. This would be contrary to the narrative approach with its focus on client strengths and empowerment, rather than directiveness of the therapist.

A number of authors have commented on the difficulty in working with eating

disorders because of the "belief that anorexia and bulimia pose a constant health threat" (Brown, 1993a, p. 186). Feeling powerless, therapists seek to take on greater control and power through more directive focus on clients' eating behaviors. However, by taking away more of their clients' power, they are only exacerbating clients' problems, since the more powerless clients feel, the more they tend to engage in eating disturbed behavior. Brown states that "experience has taught me there is very little need to panic, and that it is, indeed, anti-therapeutic to allow such panic to shape therapy" (p. 186). She suggests contracting with the client regarding the maintenance of a minimum level of health agreed upon by both therapist and client. She concurs with the benefit of collaborating with a physician who can monitor the client's health, and states that usually the client will agree to see a physician if the client has developed a trusting relationship with the therapist or if the client herself is concerned about her health.

This was corroborated in this practicum, as two people with so-called eating disorders were referred to a physician whom they began to see on a voluntary basis. Their initial reluctance and concerns about doing so were discussed. In one case, the client had a history of negative experiences with physicians, and in the other case the client decided to see the physician when she became concerned about her increased feelings of fatigue. Both had positive experiences with the physician who was experienced in working with patients with eating disturbed behavior.

General Conclusions

It is difficult to know how effective this practicum was for clients. A major effect on the client's progress was environmental factors outside of therapy sessions, such as the

nature of parent, peer, and school related supports. This certainly backs up the narrative therapy idea that what happens outside sessions is much more important than what happens within sessions as far as evidence of progress is concerned (Freedman & Combs, 1996). There is much about the client's life that the therapist can find out only through communication with other sources than the client herself. For example, in this practicum it might have been preferable to request from all clients, rather than only a few of them, assessment material from previous therapists.

There is the question of whether intellectual understanding or insight into problems is enough to bring change to clients' lives. Knowing why they are in particular problematic situations can reveal keys to escaping those situations, and can promote understanding and compassion for themselves rather than self-condemnation. One client stated at the first session that talking therapy hasn't worked for her in the past, and that she would like to try hypnotherapy, but her parents did not approve of that approach. An alternative, less talking oriented approach may have been more appropriate for her than the practicum approach.

For the clients who seemed more inclined to be participating in therapy for reasons other than their own desire to change their lives, such as to please their parents, perhaps the benefits of participating in sessions included such aspects as the opportunity to talk about previously undiscussed issues with the therapist and/or their parents in a way that resulted in positive consequences for themselves; to have someone listen to, validate, and acknowledge their expression of their own beliefs, feelings, thoughts, and practices in a non-judgmental, accepting manner; and to have a non-coercive, trusting

relationship within a therapy context.

For the therapist, this practicum provided a valuable learning experience, and has resulted in the current goals of continuing to practise and improve implementation of the narrative approach, as well as developing more flexibility and skills in using techniques other than the verbal mode of communication.

Implications for Social Work and Future Research

With respect to eating disturbed behavior, further research is needed to deal with clients who are not only at the extreme end of the continuum of weight pre-occupation. A focus on work with less severe cases allows exploration of the more subtle beginnings of problems and on preventative issues which can more directly affect the transmission and internalization of cultural discourse that promotes such problems. Educational programs for children in elementary and junior high schools would be very beneficial in this respect.

Further research is needed in using the narrative therapy approach with all types of client populations in a variety of therapeutic contexts including groups, individuals, and families. Doing narrative group work with adolescents would provide an opportunity for adolescents to share stories, learn from peers as consultants, and support each other's preferred stories (Adams-Westcott & Dobbins, 1997). The use of qualitative research in evaluating narrative therapy seems to be a valuable tool suited to this therapy approach. At the same time, there is strong merit in supplementing that evaluation method with client self-report forms or other more direct means of client feedback.

There is much to be learned about teaching the practice of narrative therapy.

Experiential learning techniques, rather than simply reading the theory, have been recommended by Zimmerman & Dickerson (1969) who state that "narrative therapy is a therapy of experience, and that teaching it must therefore involve creating experience" (p. 267). In developing clinical skills and knowledge, it would also be beneficial to meet regularly with a group or network of people who practise narrative therapy.

For social workers in general, and especially in working with adolescents, there may be benefit to the idea described in the narrative therapy literature of the therapist having access to archives of tapes or other material by previous clients describing how they dealt successfully with problems. As such access was not available in this practicum, knowledge of the literature in general was used to refer to other people in situations similar to the clients', pointing out what strategies some of those people found helpful. It was left to clients to decide whether to adopt those strategies, with the understanding that some things work for some people and not others, and that experimenting with different tactics may result in finding ones useful to themselves.

Another advantage to social work of using archives is giving therapists access to the words used by other people facing similar problems. For example, Epston et al. (1995) describe using metaphors like " 'the concentration camp of anorexia/bulimia,' 'living death,' 'being on death row' " (p. 73), and inviting clients to assess how these fit for them, as well as having clients come up with their own metaphorical descriptions of their experience. The idea is to construct an anti-anorexia/bulimia language or vocabulary to help to oppose and undermine the power that such problems have over people's lives (Epston et al., 1995). The authors state that "the primary purpose of [this language] is to

subvert medical and lay discourses on anorexia with a new vocabulary and new language forms" to replace "the stripped down language of objectivity which holds these persons prisoner in an anorexia 'talk,' a talk that minimizes, restrains, restricts, undermines, and diminishes" (p. 74).

It is hoped that narrative therapy will be more widely used by social workers since, in comparison to other approaches, it seems to provide a more tangible means within the therapy process of implementing social work values. The value system and techniques of narrative therapy demonstrate the importance of promoting social justice for all human beings, addressing the unique nature of every individual, focusing on people's inherent strengths rather than their weaknesses, and situating problems within sociopolitical contexts. The ideas and beliefs underlying the narrative approach are extremely valuable in preventing the inadvertent disempowerment, exploitation, and pathologization of clients that can easily occur with the use of traditional therapy approaches.

Incorporating more narrative therapy theory and practice into social work and other teaching curriculums is strongly recommended. This orientation is especially significant in the value it places on therapists taking a reflexive view of whatever approach they use with clients, so that no theory, including the narrative therapy approach, takes precedence over the experience of the particular client and the particular therapist who are together constructing a unique therapeutic reality.

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APPENDICES

Appendix A: Research Ethics Committee Approval Certificate

RESEARCH ETHICS COMMITTEE APPROVAL CERTIFICATE

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba.

February 12, 1999.

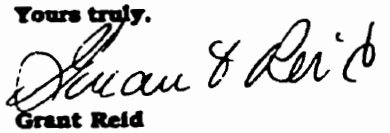
To: A. Kantor.

YOUR PROJECT ENTITLED *Narrative Therapy With Adolescent Females With Eating Disturbed Behaviour* HAS BEEN APPROVED BY THE RESEARCH ETHICS COMMITTEE.

CONDITIONS ATTACHED TO THE CERTIFICATE:

1. **You may be asked at intervals for a progress report.**
2. **Any significant changes of the protocol should be reported to the Chairperson of this Committee so that the changes can be reviewed prior to their implementation.**

Yours truly.



Grant Reid
Chair
Research Ethics Committee.
(204) (474-8455).

fax: (204) (474-7594) e-mail: greid@cc.umanitoba.ca

Appendix B: Practicum Information Sheet

Faculty of Social Work University of Manitoba Clinical Practicum

Narrative Therapy With Individual Adolescent Females With Eating Disturbed Behavior

My name is Anita Kantor, and I am a Social Work student completing the practicum project of my Masters of Social Work degree program at the Manitoba Adolescent Treatment Centre (MATC, 958-9600) at 228 Maryland Street. I am doing one-to-one counselling with young women aged 12 to 17 years old who are experiencing eating problems. I also meet with parents for at least three sessions in total (either separately or with their daughter) during the beginning, middle, and end of the program.

The counselling approach that I am using is called "narrative therapy". It focuses on the therapist and client talking about the client's experiences in the hope of learning what "stories" clients believe about themselves, about other people, and about how people should act, think, or feel about different things. Therapy involves clients making whatever changes to those "stories" they feel would fit better for them and help them to create happier lives for themselves.

My goals in this practicum are to learn and practice the narrative therapy approach in working with adolescents and to learn more about working with people who have eating problems. I plan to see a total of six to eight clients for 12 weekly 1 to 1 ½ hour sessions over a three month period. The latest date at which new referrals will be accepted is July 15/99. Participation in this project is voluntary, with clients having the right to withdraw from the program at any time without any consequence or penalty. Their ability to obtain counselling from MATC or any other program or agency will not be affected by whether or not clients decide to participate, whether or not they are chosen to participate after a screening process, and whether or not they withdraw at any point.

An initial screening session will allow adolescents and their parents to meet with me to discuss such issues as confidentiality and the compatibility of their goals for therapy with my approach. For those adolescents who have not had a previous medical assessment, an initial consultation with an MATC psychiatrist will be arranged.

Sessions will be audiotaped in order to provide me with as much feedback information as possible about how sessions are going, and therefore as great a learning opportunity as possible. All information will be stored according to MATC policy to provide maximum confidentiality. The only exception to this is that if child abuse is discovered, it will be reported to the legal authorities.

My final report will be made available to any clients interested in having a copy. Identities of clients will not be divulged in that report.

Appendix C: Practicum Consent Form

Faculty of Social Work University of Manitoba Clinical Practicum

Narrative Therapy With Individual Adolescent Females With Eating Disturbed Behavior

Consent Form

I,_____, consent to my daughter's participation in the above-named narrative therapy program for adolescents with eating disturbed behavior.

I,_____, consent to my daughter's participation in the above-named narrative therapy program for adolescents with eating disturbed behavior.

I,_____, consent to participate in the above-named narrative therapy program for adolescents with eating disturbed behavior.

I have read the attached information sheet on this project. I understand that if I agree to participate in the program, my interviews will be audiotaped. Any information provided by me in the interviews will be kept in strict confidence. My identity will not be revealed in any written reports on this project. I understand that my participation in this project is entirely voluntary. I also understand that I may withdraw my participation at any time, without consequence or penalty.

If additional follow-up interviews are conducted within the next 2 years, would you be willing to be re-interviewed?

{ } I would be willing to be re-interviewed.

{ } I would not be willing to be re-interviewed.

At the conclusion of this project, a copy of the final report will be provided to me on request.

This research has been approved by the Faculty of Social Work Research Ethics Review Committee. Any questions regarding the project may be directed to: Graduate Student, Anita Kantor (958-9600); Faculty Advisor, Kathy Levine (474-7461); or Chair of the Faculty of Social Work Research Ethics Review Committee, Dr. Grant Reid (474-8455).

Date	Signature	Witness
Date	Signature	Witness
Date	Signature	Witness

Copy 1 — Participant
Copy 2 — Research

Appendix D: Agency Consent For Assessment/Treatment/Consultation

CONSENT FOR ASSESSMENT/TREATMENT/CONSULTATION

ADMINISTRATIVE OFFICES

☐ 120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-8948

☐ 228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

PROGRAMS

HOSPITAL:

☐ Intensive Long Term Treatment Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-8948

☐ Assessment/Outpatient Services Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-8948

COMMUNITY SERVICES PROGRAM

☐ Acute Treatment & Consultation Team
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

☐ Community Child & Adolescent Treatment Services
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

☐ Educational Psychiatric Services
700 Elgin Avenue
Winnipeg, Manitoba
R3E 1B2
Phone: 786-7841 Fax: 783-6068

☐ Youth Forensic Services
170 Doncaster Street
Winnipeg, Manitoba
3N 1X9
Phone: 958-9654 Fax: 958-9633

INTAKE
Phone: 958-9600

RE: NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

MH#: 6 DIGIT: _____

9 DIGIT: _____

As the legal guardian of _____
I hereby give my permission for the Manitoba Adolescent Treatment Centre (MATC) and its delegated staff to effect therapeutic assessments and/or treatments and/or interventions according to the commonly accepted professional standards, deemed to assist in the health care of the above-named (see other side for examples).

Guardian: NAME: (PLEASE PRINT) _____

ADDRESS: _____

RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

Witness: NAME: (PLEASE PRINT) _____

SIGNATURE: _____ DATE: _____

I hereby acknowledge that I have been informed of the above information.

Client Signature: _____

H:\FORMS\CHART\Consent for Assessment Treatment Consultation.1

Appendix E: Agency Authorization For Request/Release Of Information

AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

ADMINISTRATIVE OFFICES

120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 *Fax: 783-8948*

228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 *Fax: 958-9618*

PROGRAMS

HOSPITAL:

Intensive Long Term Treatment Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-8948

Assessment/Outpatient Services Program
120 Tecumseh Street
Winnipeg, Manitoba
R3E 2A9
Phone: 477-6391 Fax: 783-8948

COMMUNITY SERVICES PROGRAM

Acute Treatment & Consultation Team
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

Community Child & Adolescent Treatment Services
228 Maryland Street
Winnipeg, Manitoba
R3G 1L6
Phone: 958-9600 Fax: 958-9618

Educational Psychiatric Services
700 Elgin Avenue
Winnipeg, Manitoba
R3E 1B2
Phone: 786-7841 Fax: 783-6068

Youth Forensic Services
170 Doncaster Street
Winnipeg, Manitoba
R3N 1X9
Phone: 958-9654 Fax: 958-9633

INTAKE
Phone: 958-9600

RE: _____

DOB: _____

I, _____, the legal guardian of the above named, hereby **REQUEST** and authorize _____
(Name of Person/Facility/Organization)

to forward any information regarding diagnosis, assessments and treatment services provided (including Psychiatry, Occupational Therapy, Psychology, Nursing, Neurology, Social Services, School) and the following specific items (please list):

_____

to: Manitoba Adolescent Treatment Centre
Address indicated in column on left side of page

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

I authorize the Manitoba Adolescent Treatment Centre to **RELEASE** to the above named, reports or findings relevant to the treatment of the above named individual (please list any exclusions/provisions): _____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

I hereby acknowledge that I have been informed of the above information.

Client Signature: _____

(This consent form expires after a two year period.)

H:\FORMS\CHART\Authorization for release exchange of info .1

Appendix F: Agency Intake Form

MANITOBA ADOLESCENT TREATMENT CENTRE - INTAKE FORM

Completed By: _____ Date: _____

Client Name: _____

Date of Birth: _____

Current Residence: Parent ☐ Receiving Home ☐ MYC ☐ PYI ☐ YECSU ☐ Other _____

Foster Parent/ Group Home: _____

Address: _____

Phone No.: _____

Referral Source: _____

Agency/ Area (CFS) _____

Relationship to Child: _____

Address: _____

Phone No.: _____

Fax No.: _____

Guardianship Status:

Parent ☐ CFS: VPA ☐ U/A ☐ TW ☐ PW ☐ Agency Area _____

If other than Parent

Name: _____ Phone No.: _____

Address: _____ Fax No.: _____

Parental Information:

Mother: _____ Father: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Occupation: _____ Occupation: _____

School: _____ Division: _____ Unit: _____

Address: _____ Grade/Program: _____

Contact Person: _____ Phone No.: _____ Fax No.: _____

Attendance: _____ Performance: _____ Ability: _____ Behavior: _____

GENOGRAM:

Client Name: _____ Page 2

Progress Note

Description of Presenting Problems

Onset	*Frequency*	*Duration*

Attachment Problems
Multiple Moves/caregivers
Self-harming
Suicide Attempts
Suicide Ideation
Substance Abuse
Temper/mood Swings
Aggressive to Others
Homicide Threat
Property Damage
Lying/blaming
Stealing
Fire Setting
Sex. Disturb./offending Beh
Running
Promiscuity
Gang Relations
Criminal Activity
Negative Peer Relationships
No Peer Relationships
Social Withdrawal
Hallucinations
Delusions / Paranoia
Thought Disturbance
Sleep Disturbance
Eating Disturbance
Enuresis
Encopresis
Poor Hygiene
Physically Abused
Sexually Abused
Neglected/rejected
Trauma / Loss
Cognitive Impairment
Other

FAMILY HISTORY OF:
Suicide
Mood Disorders
Psychosis
Alcoholism
Violence
Criminal Activity
Other

Client Name: _____

PROGRESS NOTES - Cont'd

MENTAL STATUS

Sleep / Energy: _____

Appetite / Weight Change: _____

Somatic Complaints / Medical Problems: _____

Present Medication : _____ ***Start Date:*** _____ ***Rx Physician:*** _____

Medication History: _____

Concentration: _____

Affect / Mood: _____

Thought Process: _____

Suicidality / Past & Present: _____

Client Name: _____

Agencies / Professionals Involved:

Agency	Contact Person	Phone	Date of Involvement

Service Requested by Referral Source: _____

Service Recommended: _____

To Assess / Treat / Intervene Re: _____

Date / Plan / Disposition: