"Our Voices": Narrative Group Work with Young Women Struggling Against Body and Weight Issues

By

Karen M. McKim

A Practicum Report

Submitted to the Faculty of Graduate Studies

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

OF

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ABSTRACT

This report describes the narrative group intervention used with a small group of female adolescents who struggled with weight, body and food issues and engaged in behaviors to prevent weight gain. On the group evaluation questionnaire most group members reported that they felt they had regained some control over their lives from the problem and all described the group experience as meaningful. A positive change in group members' self-esteem as measured by the Self-Esteem Rating Scale (SERS) was also observed. It is believed that the narrative practices used in this practicum significantly contributed to the rich descriptions of group members' lives and identities that emerged and that group work was not only appropriate for working with these young women but well suited to the therapeutic conversations found in narrative therapy.

CHAPTER ONE

Introduction

Background

The prevalence of problems referred to as "eating disorders" has been increasing for both the male and female populations however women continue to be disproportionately affected and make up approximately 90-95% of those suffering (American Psychiatric Association, 1994; Bordo, 1993; Madigan, 1994). In Canada it is estimated that 200,000 to 300,000 women aged thirteen to forty battle with anorexia and twice as many struggle with bulimia. Add to this, the even greater number of women who struggle with essentially the same weight, body and food issues (engaging in many of the same behaviors) but who do not meet the DSM IV criteria for a clinical eating disorder. Research involving these non-clinical populations of young women indicates that the prevalence of "partial syndrome" is at least twice that of "full syndrome" eating disorders (Shisslak, Crago & Estes, 1995). Clearly this is a significant social phenomenon.

If one conceptualizes eating disturbances along a continuum of degree (Brown, 1993; Mintz, O'Halloran, Mulholland, & Schneider, 1997; Nylander, 1971: Rodin, Silberstein & Striegel-Moore, 1985; Scarano & Kalodner-Martin, 1994) ranging from "normal" or healthy eating at one end, to "full syndrome" eating disorders at the other, then it follows that early intervention is both appropriate and necessary to prevent these struggles from escalating into full-blown eating "disorders". It has been suggested that the success of such an intervention must begin with an understanding that these problems are socially constructed and therefore can not be removed from the broader context

within which they exist (Madigan, 1994; Madigan & Epston, 1998; Zimmerman & Dickerson, 1996). A poststructuralist worldview can provide the foundation for such an intervention, while the collaborative process known as narrative therapy can assist young women to move from constricting, problem saturated stories about self to stories that are more open and preferred.

This therapeutic approach combined with group work, and the dialectical processes it promotes to advance mutual aid, provide an ideal context for young women to share stories about their personal struggles with weight and body issues. In doing so, it is hoped that personal agency is augmented as the young women begin to feel empowered to take action against their struggles – ultimately preventing these struggles from gaining more control over their lives.

Objectives

Aim of the Intervention

Ultimately the aim of the intervention was to decrease or eliminate symptomatic eating behaviors before they escalate into clinical eating disorders and to restore self-esteem. It was recognized from the onset that evaluating this outcome would require a more elaborate/complex design than what was originally proposed and therefore the following positive outcome objectives were established:

1. Group members describe the group experience as meaningful.
2. Group members relate that the problem(s) no longer have the same influence in their lives as they once had and that they have established identities outside the

dominant story. Their stories will have changed from ones that are constricting and problem saturated to stories that are more open and preferred.

3. Group members relate that they feel their sense of personal agency and self-knowledge has been strengthened.
4. A positive change in group members' self-esteem is observed when pre and post test scores on the Self-Esteem Rating Scale (SERS) are compared.

Educational Benefit to the Student

The opportunity to create a consequential group experience for young women who are struggling against body and weight issues allowed me to learn group-building techniques and to develop group intervention skills. This practicum supported my learning in the area of female adolescent identity and encouraged me to be cognizant of how these young women have been inscribed by the dominant cultural discourses.

As well, integrating narrative therapy into group work with the supportive supervision of those experienced in these interventions was an excellent way to develop clinical skills as well as confidence in approaches that were fairly new to me. Monitoring the interventive process and evaluating the outcome not only provided feedback on the intervention but also gave me the privilege of hearing the stories of the young women participating.

My specific educational objectives for this practicum were as follows:

- To further my knowledge and understanding of group development and processes.

- To further my knowledge and understanding of narrative therapy and to apply this knowledge to the development and implementation of a group intervention.
- To further my knowledge and understanding of female adolescence as well as the dominant cultural discourses surrounding young women and apply this knowledge to future work with young women.
- To improve clinical skills required to feel confident utilizing a narrative therapeutic approach.
- To develop creative means to monitor the intervention and evaluate both the process and the outcome.

CHAPTER TWO

Literature Review

Female Adolescence and the Struggle Against Body and Weight Issues

Adolescent Identity

In North America, adolescence is described as a time of vulnerability and risk for girls. Pipher (1994) likens adolescent girls to "saplings in a hurricane" (p. 22). Like others, (e.g. Bordo, 1993; Friedman, 1999; Gilligan, 1982; Gilligan & Brown, 1992), she suggests developmental changes as well as cultural expectations make them vulnerable to the storm. Like all women they are exposed to "images and ideology that press for conformity to dominant cultural norms" concerning femininity and female beauty (Bordo, 1993, p. 62).

Adolescence is also a time when girls begin in earnest to make sense of who they are within the larger context of the society in which they live. Gilligan (1982) and Pipher (1994), suggest that it is a time when our culture's messages about how girls are supposed to be (i.e. caring, compliant, empathic, subordinate and attuned to the needs of others) and how they are supposed to look start to sink in. According to Gilligan (1982, p. xxi), girls "come face to face with a social construction of reality that is at odds with their experience".

The normative cultural discourse regarding women in patriarchal society, it has been argued, shapes self-identity (Hoskins, 2002). Narrative therapists would argue that the self is not a separate identity but socially constructed. Referencing the work of Hare-Mustin & Maracek (1995) and Shotter (1989, 1990a, 1990b), Stephen Madigan, a well respected narrative therapist, writes:

> *"[A] community of discourse is a cultural creation which allows for social norms to be dictated through a complex web of social interchange mediated through various forms of power relationships" (1996, p. 50).*

How each woman is affected by our culture and its discourse is dependant on "the unique configurations (of ethnicity, social class, sexual orientation, religion, genetics, education, family, age, and so forth) that make up each person's life will determine how each actual woman is affected by our culture" (Bordo, 1993, p.62). Still, the community discourse or dominant narratives are fundamental and can have very negative implications as young women decide how to live their lives in relation to cultural expectations. Tragically, many will respond in unhealthy ways as they evaluate themselves against impossible cultural ideals seeing no other option available to them.

If we begin with the understanding that identity is to be understood as something fluid, changing and dependant on mutable circumstances or the cultural discourse, then I believe we would pay more attention to the meanings behind identities in our work with adolescent girls. For this practicum I endeavored to create a therapeutic environment where interpersonal connections were valued and the use of voice was encouraged. I believe narrative group therapy can provide young women struggling with body and weight issues the opportunity to challenge the "truths" about their identity. It is an ideal context to "give consideration to these discursive power relationships which influence how we have come to know ourselves" (Madigan, 1996, p. 53).

Body and Weight Issues Defined

A controversy has existed for some time as to whether eating disorders lie on a continuum ranging from "normal" or healthy eating at one end, to "full syndrome" eating disorders at the other (Shisslak, Crago & Estes, 1995). The alternate view is that clinical

eating disorders are qualitatively different from the unhealthy eating behaviors (and the psychological and physical consequences that accompany them) engaged in by so many young women.

The eating disorder continuum originally proposed by Nylander (1971) and further developed by Rodin, Silberstein & Striegel-Moore (1985) is fairly new and somewhat controversial. Proponents of the continuum conceptualization assert that the fundamental differences among individuals with eating disorders who meet the DSM IV criteria and individuals with milder forms of eating disturbances are "a matter of degree and not of kind" (Scarano & Kalodner, 1994, p. 356).

Mintz, O'Halloran, Mulholland, and Schneider (1997) developed the Questionnaire for Eating Disorder Diagnosis (Q-EDD) and offered preliminary evidence for the utility in operationally defining the eating disorder continuum. They placed unrestrained eating at one end of the continuum (i.e. asymptomatic group), clinical eating disorders at the other end (i.e. eating disordered group) and milder forms of disturbed eating at an intermediate point (i.e. symptomatic group). These three groups are consistent with typical operational definitions of the eating disorder continuum hypothesis as they represent increasing levels of disturbed eating behaviors.

Unfortunately there is a lack of systematic validity research on the eating disorder continuum. However, the little available research on its construct validity "has supported its conceptualization in that characteristics of clinical eating disorders such as body dissatisfaction, food & weight preoccupation, feeling fat, and the fear of becoming fat increase and self esteem decreases as the severity of an individual's eating pathology

increases" (Tylka & Subich, 1999, p. 268). These characteristics will hereafter be referred to as "weight and body issues".

Echoing the sentiment of Bordo (1993), I would suggest that all women today find themselves on the continuum "insofar as they are all vulnerable to the cultural construction of femininity" (p. 47). Indeed, beneath "disturbed" eating behaviors are issues of power, voice and individuality which are common to the struggle of women living in Western society today; a struggle that commonly begins in adolescence. Clearly then, early identification of individuals at risk and early intervention efforts (i.e. secondary prevention) are vital to prevent the development of clinical eating disorders.

For purposes related to this practicum, I believe the continuum is a useful conceptual framework for understanding the ascribed similarities and differences among groups on the continuum. I am well aware that this continuum is one of the many schemes employed by the technology of modern power[1] which makes possible the normalizing judgment of people's lives (White, 2002a). However, this practicum sought to counter the phenomenon of modern power by assisting young women to distance themselves from certain socially constructed norms about what it means to be female in our culture.

Eating Disorder Prevention

There appears to be growing interest in the area of eating disorders prevention. This gain in momentum, largely a response to the increasing prevalence of eating disorders in our society, is viewed as necessary to reduce the incidence of these tenacious disorders. It is further argued that prevention is necessary because the "treatment" of people struggling with eating disorders has been extremely unpromising with lasting

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[1] "This is a power that recruits people's active participation in the fashioning of their own lives, their relationships, and their identities, according to the constructed norms of culture – we are both a consequence of this power and a vehicle for it" (White 2002a, p. 36).

recovery eluding approximately one half of those who end up in hospitals or clinics (Hsu, 1991). Critically, Simblett (1997, p. 124) suggests the existence of a "damaging contradiction between psychiatry's presentation of self as a healing profession and its unacknowledged function as part of society's system of ordering and control". Other authors (Gremillion, 1992; Madigan & Epston, 1998; Madigan & Goldner, 1998) have expressed concern regarding the impact of a medical model approach which benefits from a special status of power and knowledge and have argued that these "treatments" can lead to actions being taken against those struggling and may even replicate the conditions of eating disorders.

Recent prevention efforts

According to Mussel et al. (2000), there have been relatively few published controlled research studies on eating disorder prevention that have evaluated the efficacy of prevention curricula. Most of the studies were conducted in junior high or high school settings (Carter, Stewart, Dunn & Fairburn, 1997; Killen et al., 1993; Moreno & Thelen, 1993; Moriarty, Shore, & Maxim, 1990; Neumark- Sztainer, Butler, & Palti, 1995; O'Dea & Abraham, 2000; Paxton, 1993 Santonastaso et al., 1999; Shisslak, Crago, & Neal, 1990;). Some were completed in college settings (Franko, 1998; Huon, 1994; Mann et al., 1997). One was delivered to students ranging from nine to sixteen years old (Porter, Morrell, & Moriarty, 1986). The majority of the programs studied were provided to females. The primary goal of these programs was to prevent the onset of disordered eating and reduce the likelihood of participants developing of an eating disorder.

Despite targeting different ages of women in several settings, these primary prevention efforts were similar with respect to the types of interventions that were

employed. All involved psychoeducation, usually with a combination of didactic and discussion formats. Emphasis for the most part, was placed on imparting information emphasizing the negative consequences of unhealthy weight control practices and encouraging the development of healthier eating and exercise patterns (Mussell et al., 2000).

Results of these prevention program studies have been disappointing. While approximately half of the studies showed that participants' **knowledge** about eating disorders had increased (Carter et al., 1997; Killen et al., 1993; Moreno & Thelen, 1993; Moriarty, Shore & Maxim, 1990; Neumark-Sztainer, Butler & Palti, 1995; Porter, Morrell & Moriarty, 1986), and some demonstrated improvement in disordered eating **attitudes** (Carter et al., 1997; Franko, 1998; Huon, 1994; Moreno & Thelen, 1993; Moriarty et al., 1990; Neumark-Sztainer et al., 1995; Porter et al., 1986), most of them failed to demonstrate efficacy through improvements in or prevention of disordered eating **behavior**. In fact, two of the studies (Carter et al., 1997; Mann et al., 1997) reported an increase in disordered eating behaviors prompting some to question the potential iatrogenic effects of such interventions.

Recommendations for future prevention efforts

In response to achieving disappointing results, many of the researchers have made recommendations for future prevention undertakings. Killen et al. (1993), for example, question the wisdom of providing a curriculum to an entire population of adolescents in a school setting and recommend that future endeavors focus on those "at risk". Similarly, Stice et al. (2000, p. 207), argue for "targeted prevention programs". As Smolak, Levine,

& Schermer (1998) suggest, it appears that secondary prevention efforts, rather than primary prevention efforts might be more appropriate.

Levine & Smolak (1998) and Striegel-Moore & Steiner-Adair (1998) suggest that another possible explanation for these unexpected and inconsistent research results may have to do with the approach used. They argue that these programs focused primarily on modifying specific target behaviors (e.g. dieting, binge eating) with the intention of reducing them and increasing those that are healthy while paying very little attention to the larger socio-cultural influences on the development of body image disparagement. They recommend that these influences not be ignored in future efforts.

Neumark-Sztainer et al. (1995) recommend that more time needs to be devoted to self-esteem and body image in prevention programs after their findings showed no improvement in these crucial areas. They also suggest that more opportunities be made for intimate discussion among participants using small groups to allow for "a deeper understanding of the factors influencing self-perceptions" (Neumark-Sztainer et al., 1995, p. 29).

Based on the disappointing prevention efforts to date as well as the above recommendations, an entirely different approach to secondary prevention is worth exploring. Narrative therapy, it will be argued, is well suited to working with young women identified as being at risk of developing a clinical eating disorder. Further, I will propose that a small group context is not only appropriate for working with these young women but also well suited to the therapeutic conversations found in narrative practice.

The Narrative Therapeutic Approach

Narrative Therapy

Narrative therapy only arrived on the scene in the late 1980s, yet with its growing popularity in professional literature it has already demonstrated its potential with a diversity of client populations. Appropriately described as "a fundamentally new direction in the therapeutic world" (O'Hanlon, 1994, p. 22), narrative therapy has intrigued and appealed to many, including social workers. In fact, there appears to be some diversity of thought in the field of narrative therapy which has resulted in differences in the ways in which therapists engage with those who consult them. Space does not permit a thorough discussion of this diversity therefore the following discussion will only speak to the form of narrative therapy associated with the work of social worker/ family therapist Michael White, of Adelaide, Australia and his colleague, New Zealander, David Epston and their colleagues. What sets this group apart from others who may be incorporating pieces of narrative therapy into their work (e.g. externalizing practices) is that these therapists recognize the socio-political cultural influence in problem making. They "act to highlight and undermine dominant cultural knowledges which act to specify, classify, and subjugate a client's identity as fixed" (Madigan, 1996, p. 50).

Historical influences. There are a number of ideas and theories, stemming from a broad range of domains that have influenced Michael White's narrative therapeutic approach over the years. Very early on, the work of anthropologist and psychologist, Gregory Bateson introduced White to the "interpretive method" which is what social scientists who believe that we cannot know objective reality refer to when they are

studying the processes by which we make sense of the world. All knowing, they argue, is an act of interpretation (White & Epston, 1990). Bateson's work also drew White's attention to the temporal dimension in therapy and to the notion of maps. It was Bateson who "demonstrated how the mapping of events through time is essential for the perception of difference, for the detection of change" (White & Epson, 1990, p. 2). White found it advantageous to combine these notions with the narrative metaphor he had been encouraged to use by colleagues David Epston and Cheryl White, seeing in the metaphor that a story is a map that extends through time.

Also highly influential in the evolution of White's narrative approach was French philosopher Michel Foucault's work. Of particular interest to White was Foucault's analysis of modern systems of power. According to Foucault, modern power has progressively displaced the operations of traditional power in the contemporary era of western culture and has become the predominant system of power in the achievement of social control (White, 2002b). White summarizes and draws out some of the distinctions that can be made between modern and traditional power based on Foucault's analysis. Only a few of these distinctions will be discussed here.

Traditional power is understood to exist at a defined centre and is implemented from the top down by those who have a monopoly on it. It is a mechanism of power that "establishes social control through a system of institutionalized moral judgment that is exercised by appointed representation of the state and of institutions" (White, 2002a, p. 44). In contrast, White suggests modern power "is a system of power that is particularly insidious and pervasive…it is everywhere to be perceived by its local operations, in our intimate lives and relationships" (White, 2002a, p. 44). Modern power establishes social

control through a system of normalizing judgment which encourages people to actively participate in the judgment of their own and each other's lives according to socially constructed norms (White 2002a, p. 43).

In his practice, White noticed how these socially constructed norms or "dominant discourses" are often taken as truth and internalized leaving people blind to the possibilities that alternative narratives might have to offer about their identities. He then proposed that people enter therapy when these dominant narratives do not sufficiently represent or contradict significant aspects of their lived experiences and keep them from living out their preferred narratives (White & Epston, 1990).

Understandings and assumptions. The practices of narrative therapy are informed by poststructuralist understandings of life and identity. This tradition of understanding is deeply historical and has implications for therapeutic practice. Following Bruner (1990), White refers to this tradition as "folk psychology", a largely displaced tradition that began to be reinstated when the social sciences underwent an "interpretive turn" in the late 1960's. In the context of this "interpretive turn", attention was given to the significance of the meanings that people attribute to experiences of life, and to the social construction of people's realities. These realities were understood to "be historical and social products, negotiated in and between communities of people and distributed throughout these communities" (White, 2001a, p. 12). Identity, it is argued is one such construction. Unlike the structuralist understanding that identity is a product of, or synonymous with the self, "postructuralist understandings account for identity as a social and public achievement" (White, 1999, p. 62).

Also arising from the "interpretive turn", came an appreciation for the extent to which people construct meaning through stories about their lives and an understanding of the significant part that these stories play in providing a context, for their experience. "[I]t is in this 'storying' experience that people derive identity descriptions that are filed into the identity categories of modern culture" (White, 2000, p. 62). These identity categories or "internal state psychologies" are distinct from those identity conclusions associated with folk psychology notions of personal agency and intentional states which feature purposes, beliefs, values, hopes, dreams, visions and commitments to ways of living. The latter "are radically open to the sort of renegotiations that have the potential to throw people's expressions of life into different lights" (White, 2001a, p. 19).

According to White (2000) another characteristic of postructuralist thought is the contrasting of the metaphors "thin" and "thick" as conceptions of life (p. 62). Grounded in this understanding, narrative therapists assist those who consult with them to separate from the thin conclusions about their lives and their identities. Narrative therapy as a process provides people with the opportunity to engage in the thicker descriptions of their lives and their identities. "As people become more narratively resourced through the generation of this thick or rich description, they find that they have available to them options for actions that would not have otherwise been imaginable" (White, 2000, p. 63).

Micro-maps for practice. Michael White offers maps to guide therapeutic explorations. Those guiding the intervention in this practicum are:

1. Externalizing conversations
2. Re-authoring conversations
3. Definitional ceremony

4. Deconstructing conversations

5. Therapeutic posture

1. Externalizing conversations

Externalizing conversations represent one possibility of many in a range of narrative practices that occur in collaboration with those who consult with us. While externalization requires a shift on the part of the therapist in their use of language, it is not simply a technique. Rather, "it is an attitude and orientation in conversations" (Morgan, 2000, p. 17). Since it is common for people to understand problems as something internal to them, thus immobilizing them from seeing alternative realities, the primary goal of externalizing is to enable people to see that they and the problem are not one and the same. In fact the credo, "the person is not the problem, the problem is the problem" (O'Hanlon 1994, p. 24) really sums up the understanding of externalizing conversations.

Through externalizing conversations, "problems that people find to be at the centre of their lives and identities, and which have often asserted a massive presence, are dramatically decentred, and significantly attenuated or dissolved" (White, 2002a, p. 35). In this way externalizing conversations are used to "unpack" some of the very negative and disabling identity conclusions capturing the lives of people who present for therapy. It is important to note that externalizing conversations are also used to unpack *positive* internalized traits or qualities (e.g. strength, competence, etc.). This can be useful to gain a richer description of their history and how they are connected to a person's problem solving skills and knowledges that might be beneficial at this time. Ultimately, the goal of externalizing then is to deprive these conclusions of the truth status that has been

assigned to them" so that they "cease to carry the authority that they did" (White, 2001b, p. 3).

In his workshop notes, White (2002b, p. 2) provides a map or structure for externalizing conversations that will be utilized in this practicum. Following, are the four categories of inquiry that constitute externalizing conversations that he identifies:

I.) Naming the problem or "[n]egotiation of an experience-near, particular, and non-structuralist definition of the problem/concern".

ii.) Mapping of the effects/influence of the problem through various domains of living.

iii.) Evaluation of the effects/influence of the problem in these domains of living.

iv.) Justification of these evaluations.

Externalizing conversations do not magically result in people being liberated from their problems. However, they do play a part in opening space for other conversations and practices to generate rich descriptions of the alternative stories of people's lives that can lead to them being able to make significant changes in their lives.

2. Re-authoring

In re-authoring conversations, the therapist collaborates with the person consulting them to reconstruct a preferred story, that is more empowering, more satisfying and more hopeful (Hoyt, 1994). The goal of this process is to increase the person's control over the problem resulting in greater internalized personal agency (Cheung, 1998). Re-authoring conversations make this possible as they contribute to the generation of a rich description of intentional states and to the identification of "knowledges of life and practices of living that are associated with these positive identity conclusions" (White, 2001b, p. 3).

Unique outcomes provide the starting point for re-authoring conversations. "They provide a point of entry into the alternative story lines of people's lives that, at the outset of these conversations, become visible as thin traces, which are full of gaps, and are not clearly named" (White, 2002b, p. 5). In re-authoring conversations, the therapist moves back and forth between "landscape of action" questions ("composing events, linked in sequence, through time, and according to a theme/plot") and "landscape of identity" questions ("composing identity conclusions that are shaped by contemporary identity categories of culture") inquiring about details of events and their meanings (White, 2002b, p. 5).

Metaphorically, White (2002b, p. 5) likens this questioning process to building a "scaffold". He suggests that by tracing the history of unique outcomes, grounding them, making them more visible and then linking them in some way, the gaps begin to fill and the alternative story lines are "thickened and more deeply rooted in history". It is through these scaffolding questions that alternative story lines are richly described and people's abilities to act in relation to the problem's influence are brought forward. These thick and rich descriptions of lives and relationships are "generative of a wide range of possibilities for action in the world that were not previously visible" (White, 2001b, p. 3).

3. Definitional ceremony

Embedded in the alternative stories of their lives are people's preferred claims about their identities. Within the context of the tradition of thought associated with narrative therapy, it is understood that these preferred identity claims become authenticated through "social processes of acknowledgement" (White, 2001a, p. 22). Drawing the definitional ceremony metaphor from the work of Barbara Myerhoff (1982,

1986), a cultural anthropologist and linking it with poststructuralist understandings of identity, White developed therapeutic applications. He uses this metaphor to structure the therapeutic arena as a context "for conversations that engage outsider-witnesses in the telling and retelling of the stories of each other's lives" (White, 2002, p. 9). Outsider-witnesses can be family members, friends, peers, professionals or others who having previously sought therapeutic consultation around similar problems and have volunteered to participate (White, 2001a).

In this map there are four stages to the process. To start, the individual/family who is consulting the therapist is at the centre of the ceremony. The individual/family engages in a re-authoring conversation while the outsider-witnesses observe, listening carefully to what is being said (Morgan, 2000). In the second stage, guided by principles and ethics of narrative therapy, the outsider-witnesses respond to the tellings with retellings while the individual/family and therapist observe. Here outsider-witnesses are asked to be mindful that what they are speaking to is the experience of the individual/family at the centre and how that person's experience resonates with them. These retellings contribute to the rich description of the conversation just witnessed and are viewed to be powerfully authenticating of preferred identity claims.

The next stage of the ceremony involves a second retelling. Those whose lives are at the centre of the ceremony are encouraged to share their thoughts and feelings about the responses that they have just heard. They are also invited to speak generally about the experience. Finally, all participants are brought together and there is an opportunity for all to reflect and comment on the process (Morgan, 2000).

For the purposes of this practicum, the previously described process was modified somewhat but the principles remained the same. To start, one group member volunteeered to be at the centre where I facilitated a re-authoring conversation with her. The remaining group members listened and observed. In the second stage, to ensure that the outsider-witness retellings were linked back to the life of the person at the centre, my role was that of interviewer and facilitator (i.e. I did not remain a passive observer to the process). In addition to adopting a central role in the process, I created and distributed guidelines for the listening group to help facilitate the thoughtful and rich retelling process I hoped for (Appendix A). I did not participate as a group member in this activity.

In his group work with gay men, Behan (1999) also chose to utilize his knowledge and his expertise to link group members' lives in meaningful ways. His experience taught him that adopting this dual role ensured that the person's preferred claims about life and identity would be acknowledged and more thickly described.

In the third stage, the group member at the centre was encouraged to reflect on what she had heard and finally, all group members (including myself) reflected on what was shared and the process in general. This definitional ceremony was repeated for 4 of the 5 group members (one group member was absent for most of these sessions).[2]

Unlike a common group therapy format with an unstructured conversational style, the more structured definitional ceremony process has the potential to "thicken group members' descriptions of their lives in ways that would enable them to step into new ways of being" (Behan, 1999, p. 21). While a typical group therapy format uses taken-for-granted practices such as affirmations and positive feedback, the definitional

[2] Please see "Challenges and Successes" for further commentary on the use of the definitional ceremony.

ceremony creates opportunities to link group members' lives in meaningful ways and structures the group's time in a way that will "maximize the authentication of members' identity claims" (Behan, 1999, p. 21).

4. Deconstruction

Another map that was utilized in this practicum is that of deconstructing conversations. This practice involves situating the problem in context and exposing the role of dominant, often subjugating, discourses. Revealing the role of subjugating dominant discourses brings "socio-historical, cultural and political realities into the therapy process" (Cheung, 1998, p. 8). This fits well with social work, a profession which prides itself on its ability to address injustice at many levels.

The underlying assumption of this practice is that problems only survive when they are supported by particular ideas, beliefs, practices and principles of the broader culture in which a person lives. These notions are often taken for granted and regarded as "truths". An excellent example of this is eating disorders which only survive in cultures where "thinness is generally regarded as more beautiful"...where "a woman's appearance is often taken as a measure of her character and worth"...and where "qualities such as *self-discipline, self-control,* and *niceness*" are regarded as virtues (Maisel, Epston & Borden, 2004, p. 24).

In a deconstructing conversation the therapist works with the people consulting him/her to further examine these dominant notions, tracing their history and evaluating their effects. The goal is to assist people to expose and "unpack" these dominant ideas, freeing them from their influence and altering their relationship to the problem. Often revealed in these discussions are the more neglected times in a person's life when they

stood up to the dominant ideas and beliefs that support the problem. If these times are viewed as significant to the person, they are identified as "unique outcomes" and can become openings to alternative stories.

5. Therapeutic posture

The intention of the therapist situated in a narrative therapeutic context is to engage in collaborative, horizontal relationships and to focus on expanding and enriching meaning more that on encouraging new behavior (Combs & Freedman, 1994). In conversations with those who consult with them, narrative therapists are co-creating meaning.

Anderson & Goolishian (1992) propose that the therapist take a "not knowing" position that privileges the person's lived experience. To facilitate this, the therapist is reflexive and their "stance is one of curiosity rather than certainty with a focus on assisting the client's agency in the direction of their life" (Nicholson, 1995, p. 24). White (2002b) suggests the therapist take up a "decentred and influential" posture in conversations. Being decentred refers to "the therapist's achievement in according priority to the personal stories and to the knowledges and skills" of the people consulting them (White, 2002b, p. 4). While being "influential" refers to the therapist's skill in building a scaffold through questions, making it possible for people to more richly describe the alternative stories in their lives.

Research on narrative therapy. While a good deal of anecdotal evidence of narrative therapy's effectiveness and its success can be found in the literature (Freedman & Combs, 1996; Smith & Nylund, 1997; White & Epston, 1990; Zimmerman & Dickerson, 1996), there is very little in the way of empirical evidence. Etchison & Kleist

(2000) reviewed the literature in this area and uncovered four studies (Besa, 1994; Coulehan, Friedlander & Heatherington, 1998; St. James-O'Connor, Meakes, Pickering and Schuman, 1997; Weston, Boxer & Heatherington, 1998) that provide support for the use of narrative approaches with families.

In one study, Besa (1994) examined the effectiveness of narrative therapy (White & Epston, 1990) in reducing parent-child conflicts. Using a single case research design, he concluded that treatment incorporating several narrative techniques resulted in a decrease in parent-child conflicts. In another study, St. James-O'Connor et al. (1997) used an ethnographic research design to examine families' perceptions of their narrative therapy experience and the meaning that these families attributed to this experience. Their results showed narrative therapy to be "empowering personal agency in family members" (Etchison & Kleist, 2000, p. 3). Similarly, Weston, Boxer & Heatherington (1998) utilized quantitative and qualitative research methodology in their exploratory, descriptive study, to examine children's stories about the causes of family arguments and concluded that appreciating these stories could "aid therapeutic work with the family as a whole" (Etchison & Kleist, 2000, p. 3).

In a fourth study, Coulehan, Friedlander, & Heatherington (1998) utilized a qualitative method of constant comparison to analyze data gathered in their exploratory study of Carlos Sluzki's narrative approach to therapy. These researchers concluded that in three out of four sessions, parents' descriptions of the problem had shifted.

In examining potential reasons for the shortage of research on the utility of narrative therapy, Etchison and Kleist (2000) point to the inconsistencies between traditional quantitative empirical research and narrative therapy with its constructivist

orientation. They suggest qualitative research methods however appear to be well suited to researching the effectiveness of narrative therapy.

A Narrative Approach to Body and Weight Issues

There is no literature specifically suggesting that narrative therapy can prevent eating disorders. However, there are a number of documented examples of narrative therapy being used when working with young women who have been diagnosed with clinical eating disorders (Epston, Morris & Maisel, 1995; Eron & Lund, 1996; Grieves, 1998; Kantor, 2000; Kraner & Ingram, 1997; Madigan, 1998; Madigan & Epston, 1998; Madigan & Goldner, 1998; Maisel, Epston & Borden, 2004; White & Epston, 1990; Zimmerman & Dickerson, 1994). Grounded in a very different understanding of the problem these narrative therapists have taken a very distinctive approach to this work. To start, they argue that eating disorders are socially constructed and therefore can not be removed from the broader context within which they exist (Madigan, 1994; Madigan & Epston, 1998; Zimmerman & Dickerson, 1996). They recommend deconstructing eating disorders in an effort "to bring forth for discussion and contestation the gender, cultural and social context of such problems" (Madigan & Epston, 1998, p. 127). Maisel, Epston & Borden (2004, p. 24) suggest that the influence of Western cultural values is a general predisposing factor and that other circumstances can contribute to someone being more receptive to so-called eating disorder's "accusations and false promises". The following are some of the common circumstances encountered by people they know struggling with eating disorders:

- Activities or professions that place bodies on display

- Contexts that emphasize achievement and competition
- Situations where one feels out of control of one's body or life
- Feeling demeaned and belittled by others
- Emotionally overwhelming events
- Periods of life transition
- Professions or activities that encourage self-sacrifice and selfless giving
- Family contexts that promote achievement, perfection, thinness, or guilt (Maisel, Epston & Borden, 2004, p 25-27)

Since eating disorders are particularly oppressive problems, "a combative approach" (Freeman, Epston & Lobovitz, 1997, p. 65) in which the problem is labeled and opposed is indicated. According to Madigan & Epston (1998, p. 127), this requires a "radical externalizing conversation" in an effort to understand the internalized problem discourse. Unlike more traditional therapeutic approaches where the person's alternative knowledge has been largely excluded, Madigan & Epston (1998) encourage professionals working with this population to "question popularized therapeutic traditions" and to collaborate with people against eating disorders rather than seemingly working against the person and/or their family. In this way narrative therapy strives to create a climate conducive to resistance that will ultimately support an individual's stand against eating disorders. I believe it is can also be useful in supporting individuals struggling with "symptoms" of these disorders.

Narrative Therapy and Group Work

From a narrative perspective, there are a number of advantages of a narrative approach to group work. Perhaps the most useful function of the group is that "it becomes an audience for members' developing preferred descriptions of themselves" (Silvester, 1997, p. 245). Group work also provides additional opportunities for

connections to be made and can enable people to work together to resist or defeat a common problem. Despite acknowledgment of the potential advantages of a narrative approach to group work, its actual application has only recently been explored and therefore the literature in this area remains scant. However, the few pioneering efforts that have been described show promise.

The initiatory work of O' Neill & Stockell (1991) was a significant step in the progression of narrative therapy developing a broader communal focus (Vassallo, 1998). Their writing outlined a process for narrative group work which provided people diagnosed with schizophrenia "the opportunity to develop new meaning and understanding in their lives" (p. 206). Other practitioners have since creatively applied the narrative framework within a group format to help those struggling against depression (Johnson, 1994; Laube & Trefz, 1994), to assist gay men (Behan, 1999), to assist young women who have experienced sexual assault (McPhie & Chaffey, 1999; Mann & Russell, 2002), to help people with a history of psychosis (Vassallo, 1998) and in work with couples where one partner has a history of childhood sexual abuse (Adams-Westcott & Isenbart, 1996). Silvester (1997) has used narrative therapy in his groups to teach assertiveness to women and to people with disabilities and also to support parents, while Augusta-Scott & Dankwort (2002) have proposed that a narrative therapy approach in group intervention with men who batter might be promising work. There are only two examples that demonstrate the usefulness of this approach with young women struggling with eating disorders (Kraner & Ingram, 1998; Zimmerman & Shepherd, 1993) and another that utilizes narrative techniques to address issues of body image, weight and self-esteem (Daigneault, 2000).

Despite numerous variations in how narrative therapy is defined and utilized by practitioners in the previously mentioned examples, each has demonstrated that group work can offer an interpersonal vehicle for illuminating individual stories. Of particular interest and inspiration to me were two of the more recent examples (Behan, 1999; Mann & Russell, 2002). These practitioners introduced the use of definitional ceremonies and outsider-witnesses into the therapeutic context and found these practices to contribute significantly to the rich descriptions of group members' lives and identities.

From a narrative perspective, group work with adolescent girls struggling with body and weight issues would allow "members not only to have an audience to the performance of new stories and new constitutions of self but also to be an audience to others' new stories and constitutions of self" (Freedman & Combs, 1996, p. 255). Group work also has the potential to create a supportive space for challenging the cultural and socio-political messages that dictate and influence identity. In this way narrative therapy offers a means to link clinical practice with social action, areas which have tended to remain separate in the social work profession.

CHAPTER THREE

The Group: "Our Voices"

Pre-Group Preparation

Recruitment Strategies and Challenges

The criteria for participation in the group were identified as follows:

1. Young women between the ages of 14 and 16.
2. Do NOT meet DSM IV criteria for an eating disorder but nevertheless struggle with weight and body issues. These issues may include:
   -body dissatisfaction
   -food and weight preoccupation
   -feeling fat
   -fear of becoming fat
   -unhealthy weight loss strategies
3. Believe these issues to have had an impact on their ability to live a full and pleasurable life.

Recruitment for a group planned for February 2004 started in November 2002. An information package (Appendix B) which included a recruitment letter detailing information regarding dates, the criteria identified above, group format, potential benefits, the referral process (as well as a referral from) and screening was mailed out to all schools in the city where young women between the ages of 14 and 16 could be attending.[3] The same information was distributed to community health clinics, agencies providing services to youth and families, Centralized Intake for Child and Adolescent Mental Health Services and education support services in the various school divisions.

[3] Information packages were sent to the attention of school counselors at each school.

An ad was placed in my agency's newsletter (Macdonald Youth Services) and ad was also created for a local teen "zine" (Appendix C) which was distributed to all senior high schools. It was my hope that this in addition to "word of mouth" via myself and my colleagues would be sufficient to recruit a minimum of 5-7 potential group members for the first group. I also fully expected that I myself would be able to identify potential recruits from my own caseload having met numerous young women in the past who would have met the criteria I had established. Given my belief that struggles with body and weight issues are prevalent in the adolescent population, I truly believed that recruitment would be a relatively easy task. Unfortunately this was not the case and I was both surprised and disappointed to find that despite several calls of inquiry and even some calls of praise and encouragement, by the referral deadline I had received only three referrals.

With only three participants identified I decided to postpone the start date and try another round of mailings – this time including an "eye-catching" poster I had created to post (Appendix B). I give credit for this idea to a school counselor who told me that she had created a poster using the information I had sent her (first mailing). She placed the poster in the women's washroom and an interested young woman had come forward to inquire.

Again there were inquiries and praise but no outpouring of referrals. However a residential treatment home called to see if they could send all four girls in their care - I agreed to accept one. Then a previous referral source called to say that she had another referral but this was a friend of the young woman whose referral I had already accepted. This created a dilemma for me. I did not want to turn away a suitable recruit but I was

concerned about the potential negative impact this pre-existing friendship could have on group dynamics. After consulting with my colleagues and group advisor I decided to include this young woman bringing my total solid referrals to five.

Screening, Orientation and Engagement

Keeping with the principle of homogeneity which suggests that "members should have a similar purpose for being in the group and have some personal characteristics in common" (Toseland & Rivas, 2001, p. 167) screening was necessary. An effort was made to select individuals whose body and weight issues fall at a similar place on the continuum of eating disturbances previously described.

The initial telephone screening served its purpose. Through consultation with the referring practitioner and reviewing criteria together, several young women were not included. For some this was due to not meeting the age requirement. In a few cases the issue was that the young woman was identified as "obese" and through exploration and careful consideration it was agreed that this could set up uncomfortable situations of comparison and potentially negatively impact on group cohesiveness as well as group dynamics.

Once the possible group participants were identified, pre-group meetings were scheduled to meet and orient the young women and their parents/guardians. Meetings were held in the room where the group would be convening. At this time information regarding the group was shared, consent forms were signed and confidentiality was explained.[4] I then met with each young woman individually, engaging her in a conversation to explore her interest and commitment to attending. The young woman

[4] Two of the group members who were age 16 were permitted to sign their own consent forms. One group member was not living with her legal guardian at the time and the other chose not to inform her parents of her participation in the group.

was then left alone to complete the Self-Esteem Rating Scale (SERS) created by Nugent and Thomas (1992) and the Questionnaire for Eating Disorder Diagnosis or Q'EDD (Mintz, et. al. 1997).

The Questionnaire for Eating Disorder Diagnosis (Q'EDD). The Q'EDD proved to be a useful tool in the screening process (Appendix E). It was essentially an assurance measure used to ensure that the young women referred indeed met the previously identified criteria.

The Q' EDD is a self-report questionnaire that contains 50 questions and requires 5 to 10 minutes to complete. It yields both frequency data for individual behaviors (constituting DSM-IV eating disorder criteria) and categorical labels (Mintz et al., 1997). As detailed in Mintz et al. (1997), respondents to the questionnaire are placed into diagnostic categories based on the scoring manual decision rules.[5] For the purposes of this practicum I was only interested in the most general level of categories i.e. non-eating-disordered and eating-disordered. Psychometric data exists to support the use of the Q'EDD for making this differentiation (See Mintz et al., 1997).

The non-eating-disordered category is comprised of two other categories: asymptomatic (i.e. no eating disorder symptoms) and symptomatic (i.e. some eating disorder symptoms but no DSM-IV diagnosis).[6] As a screening tool, the Q'EDD was used to ensure that only young women identified as "symptomatic" were invited to participate in the group. The purpose of using such an instrument was <u>not</u> to classify young women but rather to ensure that the group participants would have similar

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[5] To obtain a copy of the Q'EDD, including the scoring manual, and for permission to use this tool contact Laurie Mintz at the University of Missouri (MintzL@missouri.edu).

[6] The eating disorder category is comprised of six specific diagnostic categories reflecting the DSM-IV diagnoses.

experiences and therefore could relate to and support one another. I was also aware of the potential iatrogenic effects of bringing together young women at varying points on the continuum and wished to avoid this.

After scoring the Q'EDD, four of the five young women were identified as "symptomatic" and one was initially identified as "asymptomatic" due to answering "no" to all questions pertaining to strategies utilized to prevent weight gain. After taking into consideration how greatly this individual's weight influences how she feels about herself, her responses to some of the other questions regarding beliefs about her body and her interest in participating in the group, I decided to include her. (See Group Participants for further discussion on this matter).

The Group

Setting and Structure

The setting for this practicum was Macdonald Youth Services (MYS). According to its mission statement, MYS "is a registered, charitable organization dedicated to providing a range of quality assessment, treatment and support services to individuals, families, and communities, with an emphasis on children and youth. Macdonald Youth Services believes in holistic services, maintaining and promoting dignity and self respect".

The group was run out of the St. Mary's office location, centrally located within the city. A medium sized therapy room/meeting room was utilized and proved to be conducive to sharing and discussion (i.e. warm, comfortable, appropriate seating etc.) As well, this space facilitated participation in art activities that required the use of a table and chairs.

The group consisted of five group members and one facilitator (myself). In an effort to foster a greater sense of cohesion, it was felt that the group should remain closed, thus the importance of discussing group members' interest and commitment prior to the group commencing. A review of the literature suggested five to nine members as an ideal group size (Toseland & Rivas, 2001; Malekoff, 1997; Friedman, 1999). The consensus appeared to be that the group should be small enough to allow members optimal opportunity for participation. It was this knowledge, in addition to space limitations, the number of sessions and recruitment challenges which dictated that group size in the end.

Duration and Frequency

The literature suggested that the group needs to run long enough for members to build trust and develop relationships and offered eight to twelve sessions as an appropriate frequency. In order to allow the opportunity for each member to be at the centre during the definitional ceremony component of the intervention and also allow time for additional activities planned, including evaluation pieces, the group was run once/week for twelve weeks. Coincidentally, by the time the group started after Easter, there were only twelve weeks until the end of the school year.

Ninety minutes was identified as the amount of time per session to allow enough time for the intervention activities but not enough time for group members to get bored (Lecroy & Daley, 2001). However, this was changed after the mid-group evaluation to two hours at the request of the group members.

Rules and Therapeutic Posture

In our initial session, the following group rules were created and agreed upon by the group members:

"Happy Comfy" Rules:

- *Be respectful*
- *Have the right to pass (i.e. not speak)*
- *Listen when others are talking*
- *Focus*
- *Confidentiality*
- *Show up! (be on time)*
- *Have fun! (lots of it)*

While it was my intent to maintain a therapeutic posture consistent with what I have come to understand as being appropriate in a narrative therapeutic context (as described in literature review), I found my role as facilitator of the group sometimes challenged this. Sessions were preplanned and structured and at times almost scripted (e.g. what questions would be asked to prompt discussion) leaving less opportunity for individual group members to play a more significant part in mapping the direction of the journey. The exception to this was during the definitional ceremony sessions where priority was given to the individual's personal story. Here, I made an honest effort to maintain a curious, "decentered and influential" stance (White, 2000b).

Recording

All group sessions were audio recorded (footnote re tape recorder was turned off when art pieces were being created) as a means to gather information as unobtrusively as possible for evaluation purposes. In pre-group meetings all participants indicated that this would be fine. It was hoped that client reactivity and bias could be minimized with audio recording occurring in every session, not just the two sessions where the content

would provide data for analysis. I believe this was the case as the tape recorder simply became a permanent fixture in the middle of the room. Unfortunately despite being centrally located, the sound quality at times was poor.

Recording all sessions proved to be beneficial to my own learning as I was able for example to review the definitional ceremony sessions and reflect on both the content of these conversations as well as my role as therapist vs. group facilitator in them. Also, given the gap in time between the running of the group and the writing of this report, I am thankful to have audio tapes to refer to.

Group Participants

Similarity & Diversity

There were 5 group members ranging in age from 14-16. All were attending school and indicated that education was important to them. Three of the young women resided with their family of origin, one was a ward of Child and Family Services and lived in group care and one lived with extended family. Of the five young women, only one was a visible minority. While all identified English as a first language, most spoke other languages as well (in varying degrees of fluency). All group members clearly identified struggles with body and weight issue and all felt that these issues had had an impact on their ability to live full and pleasurable lives.

In our first session, the group brainstormed a list of struggles that brought them to the group. While some items on the list did not apply to all group members (e.g. "binge-eating", "depression", and "pill-popping"), there appeared to be consensus on other items. These included: "not measuring up", "self conscious", "ashamed", "no or low

confidence", "low self-esteem", "need to lose weight", "things would be better if I was different", "never good enough", "guilt", "sadness" and "hurt".

Through the process of scoring the Questionnaire for Eating Disorder Diagnosis (Q'EDD), additional similarities amongst group members were identified. As well, some of the dissimilarities between one group member and the rest of the group were also noted. As reported earlier, the Q'EDD results identified four of the five group members as being "symptomatic", with the fifth group member being included after careful consideration despite the Q'EDD results identifying her as being "asymptomatic".

Part of the scoring of the Q'EDD involves identifying individuals' Body Mass Index and then determining which weight category they belonged to (i.e. severe underweight, low weight, normal, overweight, moderately obese, grossly obese). While I dislike the use of categorizations, there is some interesting data to report on here. For example, four out of five of the young women fell within the "normal" range for weight category and one was considered "moderately obese". All answered "yes" to one of the following questions:

- *Certain parts of my body (e.g. my abdomen, buttocks, thighs) are too fat.*
- *I feel fat all over*

All also indicated that they would like to lose weight. The desired amount of weight loss for those in the "normal" category ranged from 8-15 pounds while for the one individual identified as "moderately obese", the amount was 75-100 pounds. What is particularly interesting about these figures is that even if all members lost the desired amount of weight, they <u>all</u> fall within the "normal" weight category. Perhaps this is a positive thing (i.e. no one would be identified as a health risk because they became "severely

underweight"). However, one wonders also about the potential power such categorization could have on these young women (and any young woman for that matter) if they were aware of such a tool and then determined that "normal" and "not good enough" were synonymous. I believe this is a very real concern given the discussions we had around the theme of "not measuring up" (see Chapter 4).

The individual identified earlier who was by the Q'EDD standards identified as "asymptomatic" was also the individual who was identified as "moderately obese". I will call her Lucy (pseudonym) from henceforth. It is not the labels I wish to draw attention to but rather my own failure in predicting the potential struggles for this young woman as a participant in the group. I believe that in my eagerness to accept Lucy as a group member after the initial screening process I focused on the similarities of Lucy's struggles to others. In doing so, I believe I minimized what Lucy may have perceived as significant differences between herself and the others. I was ill-prepared for the consequences of my inconsiderateness.

Clearly Lucy did not need a questionnaire to see a discrepancy between her body type and the others when she entered the room for the first session. I learned days later from Lucy's mother that the discussion in that first session regarding the struggles that brought the young women to the group also contributed to her feeling like she was "different" and like maybe she didn't belong. This left Lucy understandably upset and not wanting to return. Thankfully, after a discussion about group members' similarities I was able to convince the mother of my belief in the group's acceptance of Lucy and she encouraged Lucy to give it another chance – which she did. The point I wish to make on this issue of diversity is that my insensitivity almost resulted in the loss of a group

member. Had I taken the time prior to the group commencing to meet with Lucy to discover her fears and perhaps prepare her for some possible challenges to her confidence, I think things would have gone much smoother. Thankfully, the outcome for Lucy was a positive one. Likewise I believe everyone benefited from her presence and participation.

Pre-Intervention Measure of Self-Esteem

The Self-Esteem Rating Scale (SERS) created by Nugent and Thomas (1992) was used as a pre and post intervention measure of self-esteem (Appendix F). Group members completed the questionnaire at the pre-group meeting. This 40-item unidimensional instrument not only measures low or "problematic" levels of self-esteem but also positive or nonproblematic levels. Scores can be both negative and positive in value but it is possible for someone's score to improve even though it was already a positive value (e.g. from +5 to +25). This was the most appealing feature as I was interested in measuring <u>any</u> increase in self-esteem. Three other self-esteem measures, the Hare Self-Esteem Scale, Hudson's (1992) Index of Self-Esteem (ISE) and the Rosenberg Self-Esteem Scale (see Corcoran & Fischer, 1987 for all), were considered but discounted for this reason.

Fischer and Corcoran (1997) report that the SERS has excellent internal consistency, with an alpha of .97. The standard error of measurement was 5.67. The SERS was reported as having good content and factorial validity. It also has good construct validity, with significant correlation with the Index of Self-Esteem and Generalized Contentment Scale as predicted.

The scores for the pre-group questionnaires are presented below. These results will be compared to post-group results in the summary of evaluation results in Chapter 4.

Table 1
Pre-group scores on the Self-Esteem Rating Scale (SERS).

Name	SERS score
Susan	10
Amber	-60
Lucy	9
Colleen	-32
Jackie	-11

Review of Intervention Activities Utilized

The intervention was largely based on a narrative theoretical framework. Following the micro maps for practice identified in the literature review it was a collaborative, interactive process of: eliciting stories, externalizing problems, deconstructing problem stories and developing alternative, preferred stories of life and identity. The group also included some structured activities (e.g. check-ins, icebreakers) to generate discussion and participation. I believe some structure was helpful in the first few sessions to increase feelings of safety, reduce anxiety and diminish the possibility for conflict. More activities designed to help members get to know one another probably would have been advantageous. I was hesitant to have too much structure, not wanting to create social control dynamics which might restrict members' ability to share their stories freely.

Art was used to augment self-expression and to aid the process of externalization and other deconstructive practices. Zimmerman & Shepherd (1993) suggest that art

allows members to express themselves in their own personal way and can be a powerful tool for change. I believe this will be clearly demonstrated in the following chapter. The art work created also became a useful tool in the evaluation of the intervention. The process for eliciting the art work was semi-structured. Once a name for the problem was established through an externalizing conversation with the group and the problem's attributes and qualities were also identified the group members were asked to reflect on the problem's influence on their lives and relationships and to create a picture to illustrate this. Various art supplies were provided giving members numerous options for creating a representation of themselves and of the problem's presence in their lives.

Once the participants completed their artwork they were encouraged to share their story with the other group members, attending to the meanings attributed to the details in their pictures. The art work was saved until session # 11 when it was returned to its creator and the identical process just described was repeated. This time however, members were encouraged to first reflect on their first piece of art and consider whether or not their view of themselves and their relationship to the problem had changed in the course of the group. They were then asked to create a second picture representing these reflections to be shared with the group.

Five sessions were allocated for the definitional ceremony process to occur however only four participants participated in this process due to one member being absent during the latter of these sessions. The group was structured in ways to ensure that each group member's story was privileged. As previously discussed, my role in this process was that of interviewer and facilitator. Guidelines were provided to the group to

ensure that as outsider-witnesses their reflections were linked back to the person at the centre (Appendix A).

In an effort to both preserve and thicken the alternative story that was discovered through these conversations, a "document of identity" was created for each of the participants in this process as an account of their personal agency (Appendix G). Michael White makes reference to this kind of document in an interview regarding his work with people who have experienced psychotic episodes. He suggests that "[i]n times of stress...we are all vulnerable to being separated from our knowledgeableness" (1995, p. 142). When our knowledgeableness is compromised our sense of identity is also at risk. This can lead to insecurity and distress. Thus having a document of identity to consult with during these times of duress or under those circumstances when the problem might challenge us once again seems apt.

Since only four of the five sessions allocated for definitional ceremonies were utilized, part of the left over session was devoted to self-care and relaxation strategies. In addition to discussions pertaining to these topics was a guided imagery activity.[7]

To end the group, a celebration was organized by the group members. They were given the opportunity to plan how they would like to acknowledge and celebrate their group experience. It was suggested that this was a time for them to congratulate themselves and each other for finding their voices. The group decided to order pizza and go bowling together after a small ceremony where they were each given a rose and a certificate of participation (Appendix H). Each group member signed the other group members' certificates.

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[7] The guided imagery activity can be found in Susan Carrell's 1993 book entitled "Group Exercises for Adolescents" (See References).

CHAPTER FOUR

Evaluation

Discussion of Themes Identified Through Intervention Activities

The intervention activities just described resulted in the creation and co-creation of stories. Uncovered in these stories was a wealth of insider knowledge. In an effort to condense this knowledge so as not overwhelm the reader I decided to focus on three themes that were unearthed in the course of the group. I believe the following themes are not unique to the stories of the young women in the group and likely would be found in the stories of all women struggling against with body and weight issues. The very suggestion of the possibility for this generalization speaks to the reality of where these problems are situated.

Theme One: Constant Struggle

In the first session, group members were asked to share what struggles they had carried with them to the group. A list was created on poster paper (Appendix I). Group members were then asked to consider if there was a name befitting these struggles. Despite what appeared to be a varied list, the group was able to reach a consensus on a name they felt was representative of everyone's struggles.[1] They chose the acronym "H.I.M. (HIM)" which they agreed could stand for two possibilities: "Hurting in Myself" or "Hate in Me". In the end most group members expressed a preference for "Hurting" or "Hurt" feeling that "Hate" although at times a true representation of their view of the problem, was too narrow. With regards to the name chosen, group members were keenly aware that they had given the problem a male identity. The explanation for this was

[1] In later sessions some group members chose different names for their problems. This will be evident in the discussion that follows.

simply their perception that HIM's qualities seemed more masculine. In hindsight I wish that we had explored this further - perhaps as a lead in to a discussion regarding the social location of the problem. With a name for the problem, an externalizing conversation with the group regarding HIM's influence in their lives was initiated. It was here that the unrelenting nature of the members' struggle was first noted. HIM was described as having the following qualities:

bossy, mean, aggressive, smooth, untrustworthy, charismatic, hard to get along with, controlling, egotistical, powerful, a liar, a fake, a hater.

Group members expressed feeling like they were constantly under HIM's gaze, like they were in a hurtful relationship, like there were prisoners. They also described the influence of HIM in their lives as being unwanted but at times unavoidable. I believe this externalizing conversation with the group in many ways generalized the young women's struggles creating a sense of community – a context where the young women could feel connected to one another and separate from HIM.

Further evidence for the persistent nature of the struggles can be found in the first pieces of art work created by group members and in their stories about these. As previously explained group members were asked to reflect on their present relationship with HIM and then create a picture to illustrate this relationship. Some of the young women used magazine images to create collages while others chose paint, markers or pencil crayons as their medium. All made reference to a struggle which appeared to be constant – relentless.

Amber's picture was a collage of models with the words "fake", "happy?", "eating disorders", "impossible", "perfect!", "degrading", "reality", "low self esteem", "air

brush" and "suicide" written over top. To her the challenge of measuring up to these portrayals of perfection is unrealistic. Yet, she finds herself believing that in order to be accepted and to succeed, this is the ideal she must achieve. She attributes this belief to HIM.

Figure 1. Amber's picture from the first round.

> *"Yeah well like all the models are fake or plastic or whatever and they're not real, they're not natural – but in order, you know, to fit in with society you have to look like them and then you'll be accepted. I still struggle with it to this day"* ... *"Just having to look at them all the time...HIM has like destroyed by life."*

Amber speaks of how HIM has influenced her beliefs and feelings about her own body and more specifically about its impact on her "self-esteem".

> *"...if you constantly look at these models and then look at yourself in the mirror you feel 'I'm never going to be able to look like them, I'm pathetic' and then you just develop low self-esteem like 'no one would like me, no one would want to go out with me, I'm not pretty enough'."*

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Jackie's picture was also a collage. Hers consists of pictures and text (headlines) as well as her own writing/commentary over top. Across her entire picture is an "x" with the word "stop" in the middle. Jackie shares that her picture represents how she feels about HIM and the different ways he's affected her for as long as she can remember.

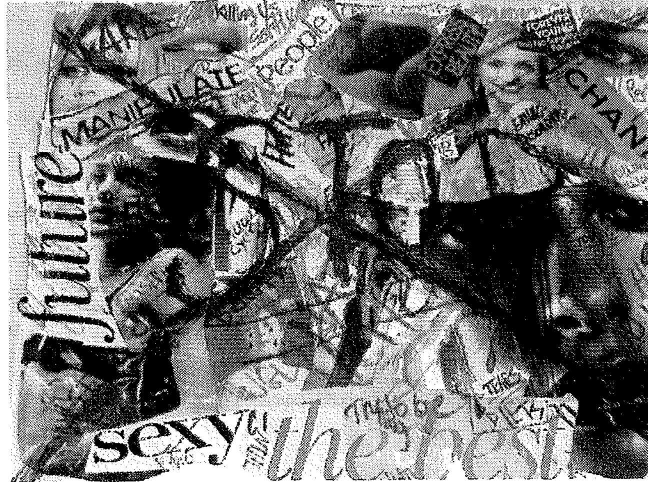

Figure 2. Jackie's picture from the first round.

Again the persistent nature of the struggle against HIM is described in the following excerpt:

> *"I've felt like my life is just a viscous cycle. Because I have so much stuff that I'm doing and on top of that I have to worry about like how I look every day. And it is just a constant struggle and feels like I'm in a viscous cycle because like sometimes I'll be like 'oh I shouldn't have eaten so much' but I needed the energy, you know, and like cause I do a lot in a day and I get really, really tired and then like so I eat more and then feel bad for eating it."*

Like Amber, Jackie also described the devastating impact this struggle has had on her self-esteem and in turn her relationships with others. She shared how HIM got her to imagine what others were thinking of her and second guess herself which contributed to her feeling very insecure and at times "hating" herself. She also discussed her knowledge of how self-hatred can lead to self-harming behaviors- apparently speaking from experience. Jackie too was critical of how pervasive HIM's defeating messages are and she expressed feeling hopeless about her future – attributing this to HIM's brainwashing.

> *"...wrecking opportunities for us because it makes us feel like we will never succeed in life and that we like can't ever do anything because we are too stupid, or we're too ugly, or fat or like ditzy..."*

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Susan's picture is a drawing of her room, "the surreal version" with poetic commentary. Using her creation to guide her, Susan described how, in the past, HIM affected and controlled her thoughts and ultimately her actions. She used a powerful metaphor to describe her victimization.

> *"Pain's harlot*
> *a striptease of hurt.*
> *Taking layers*
> *of self esteem,*
> *a crumpled mess*
> *on the floor.*
> *A fee paid in tears,*
> *a service of*
> *the soul."*

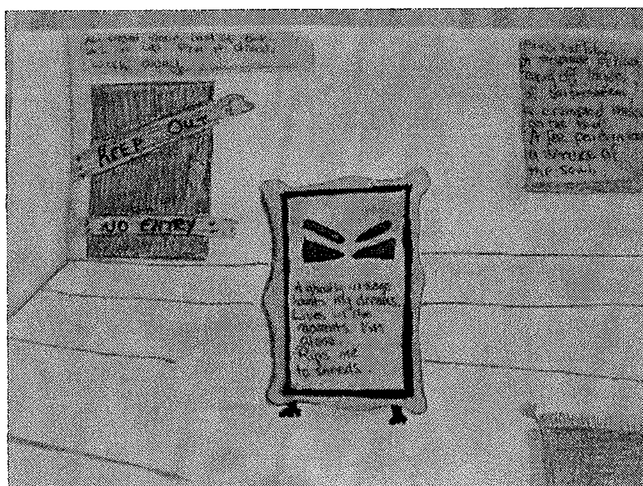

Figure 3. Susan's picture from the first round.

Susan shared that despite the success she has had in distancing herself from HIM and in stopping some of the behaviors that HIM prescribed for her (e.g. purging), she continues to feel his unrelenting pressure to join him once again.

> *"He's still constantly like pushing me. That's partly because I kind of felt like I was his in a way and it is really hard to get yourself back."*

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Colleen chose to name the problem "The Critic". Her picture is an illustration of The Critic and some of the repetitious critical messages she hears and how this makes her feel. Colleen shared that the critic often dictates how she thinks and feels. Sometimes the criticisms she hears are from others but often they appear in the internal problem conversations she has with herself. It causes her to question her beliefs and doubt herself.

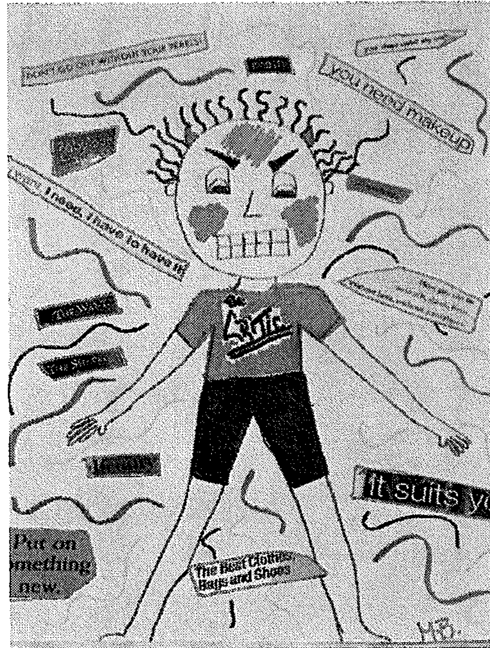

Figure 4. Colleen's picture from first round.

Colleen spoke of how she used to be a "tomboy" who played sports and never wore make-up but a new peer group influenced her to change – to become more "girlish". Her experience of feeling criticized and put down by these peers left her with a negative view of herself.

"They tell me I'm fat and stuff like that. They always put me down."

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Lucy created two quite different pictures to depict her relationship with HIM. Not surprising, a struggle is evident in both. Her first, a painting, is somewhat abstract and according to Lucy is symbolic of the "big mess" HIM has made of her life.

Figure 5. Lucy's first of two pictures from the first round.

The left side of the picture is quite dark but becomes brighter as your eyes move to the right. Lucy uses the darkness and light as metaphors for HIM's influence in her life. She shared that when his presence was strongly felt,

> *"Everyone was sad and dark and I couldn't have any fun...He was telling me that like I'd never be good enough and like stuff, that my life would always be messed up and it would never go the way I wanted it to."*

The brighter side of the painting represents more hope. There are times when things appear to be brighter. Lucy shares that her life is "still messy but it is way better than before".

Lucy's second picture is again dichotomous with the page being divided in two and Lucy wearing a mask on one side and not the other. She explains that HIM sometimes makes her wear a mask when she is around her peers so that she appears to be happy when really she is not. Lucy shared her experience of trying desperately to be like

her peers. But in order to fit in she couldn't be herself – thus the mask. A truer representation of herself, according to Lucy is on the right side of the page where we find Lucy at home wearing clothes she feels more comfortable in but still unhappy with herself. She is crying.

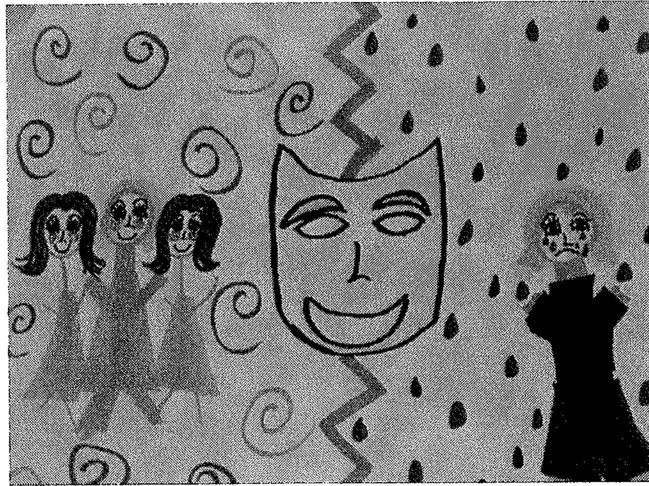

Figure 6. Lucy's second picture from the first round.

"I feel like I have to be skinnier so it makes me sad still..."

Further evidence of this constant struggle was found in my conversations with individual group members during the definitional ceremony sessions. In these conversations the young women spoke more openly of their relationship to the problem. The tricks and tactics HIM uses to influence how they view themselves - especially their bodies, and the world around them, were explored and exposed. I believe "mapping the effects of the problem" assisted the young women to challenge the truths that HIM had presented them with – truths that at times have had a totalizing effect on their lives (White, 1995, p. 22).

Despite what appeared to be a constant, unrelenting struggle, exceptions and times of resistance were identified. As the group members began to view HIM as separate from themselves and could situate HIM in the discourse of the dominant culture they were able to move away from these more dominant ideas about themselves. This opened space for considering new and preferred stories, for action and it also brought forward hope.

Theme Two: Context and Circumstances

From a narrative, post-structuralist perspective, problems are understood to exist within a cultural context. Problems thrive when they are supported by particular ideas, beliefs and principles. Therefore, engaging in conversations that deconstruct or "unpack" the often "taken for granted" practices of the broader culture is key.

If you consider for a moment that so-called eating disorders "can only survive in cultures that value thinness, where success and competence are judged in terms of body shape and size, and in cultures which promote self-surveillance and individualism" (Morgan, 2000, p. 45). Then in our work with young women struggling with body and weight issues, it makes sense to include questions which invite them to examine and challenge these problematic cultural practices. These questions might for example, draw attention to "the evolving cultural discourse of gender, consumerism/capitalism, perfectionism, the specification of policing of women's bodies, a never measuring up to culture, power relations, media, and cultural preference for thinness" (Madigan, 1994, p. 82).

In preparing/planning for the group, I wanted to ensure that time for such a discussion could occur and therefore "scheduled" a deconstruction session where I would

pose questions prepared in advance to the group to reflect on and respond to. Some of the questions asked were as follows:

- What does our culture value that might contribute to women feeling like they don't measure up?
- What is it that you think our society promotes that leaves most women with a distorted sense of their bodies? (Madigan, 1994a, p.83).
- Does the notion "thin is ideal" sway people's thoughts away from other unnoticed qualities in themselves?
- To be defined as successful, what kinds of qualities do you think women need?

These questions proved to be valuable in provoking a thoughtful and at times emotional discussion. The group members expressed frustration with the pressure they feel to adopt the norms and requirements of our society to "just fit it". Here is a sample of some of the responses:

-*"a high value is placed on appearance"*
-*"food is a luxury"*
-*"to be hot and feel sexy you have to be thin"*
-*"to get a guy that won't cheat on you will be easier if you are hot"*
-*"guys are in charge"*
-*"looks are important...looks are everything"*
-*"thin is beautiful"*
-*"thinner equals happier"*
-*"there is constant pressure from the media...a powerful force"*
-*"in order to be happy and successful you have to be like a size 3"*
-*"to be successful you have to be"... "pretty"... "you have to be thin"*
-*"to be successful you have to be a risk taker"*
-*"to be successful you have to be a bitch...you have to think of yourself before others and not be afraid to step on people to get what you want"*

Contradictions were raised and challenged as well. For example, there was a discussion about how thin is beautiful but fast, fatty foods are everywhere - and you can

even "super size" it. Similarly, there was a discussion about how far women have come in terms of their entry into the workforce with the consensus being that a woman would do any job a man could do. Yet, discriminatory hiring practices are blatant as night and day in many restaurant/bar establishments where "female, pretty, and thin are all you need to apply".

In many ways this discussion turned out to be an elaboration on some of the common cultural practices (e.g. constant comparison and perfection) the young women of the group themselves had identified in earlier group sessions when describing their relationship to HIM. Here for example are some of the things that group members had to say about unrealistic societal expectations in the first round of sharing of artwork:

Amber: *"...according to society, in order for us to succeed in life we have to look perfect like these models."*

Jackie: *"All the girls in this picture are basically like really skinny because...that's what people tell us that we have to be in order to be liked and stuff and that's basically been my goal in life...no matter what I always have to be skinny."*

Colleen cut out the following quotes from magazines that stuck a chord for her:

> *"You have to be pretty"*
> *"You got to be all woman"*
> *"You need make-up"*

Lucy: *"He (HIM) was telling me that like I'd never be good enough"... "I feel like I need to be skinnier"*

Susan: *"When I look into this mirror (in her picture) I don't see the reflection of me. I see HIM, imageless. Upon her mirror it says,*

> *"A ghostly visage*
> *haunts my dreams.*
> *Lives in the*
> *moments I am*
> *alone.*
> *Rips me*
> *to shreds."*

Jackie: *"...wrecking opportunities for us because it makes us feel like we will never succeed in life and that we like can't ever do anything because we are too stupid, or we're too ugly, or fat or like ditzy..."*

As discussed earlier in the literature review, the "predisposing" influence of Western cultural values can be exaggerated for those struggling with weight and body issues and other circumstances can contribute to and intensify this struggle (Maisel, Epston & Borden, 2004). I believe this was true for most if not all of the group members. Uncovered in individual conversations during the definitional ceremony sessions and exposed during the sharing of art pieces were some of the very circumstances referred to by Maisel, Epston & Borden (2004). Specifically the following three:

- feeling demeaned or belittled by others
- family context that promote achievement, perfection, thinness or guilt
- situations where one feels out of control of one's body or life

For example, most of the young women spoke of times when they were compared to others, "put down" or criticized usually because of their appearance. Colleen had this to say,

> *"They tell me I'm fat and stuff like that. They always put me down."*

Others had similar experiences in their lifetimes. Amber shared that this had been her experience with her parents.

> *"...and then my dad is like 'ya why don't you look like these girls in a bathing suit' and I keep saying you want me to, I'll create an eating disorder and then you'll be happy. And he's like 'well at least you would look good' and that just lowers my self esteem a great deal."*

Jackie expressed feeling overwhelmed with life and how she'd even contemplated suicide,

> *"...so many times in my life I just wanted to give up because everything just seemed way too hard and just like nothing will ever be better because problems keep arising no matter what..."*

So then, with respect to cultural specifications for women, while the media and its messages are an easy target for deconstruction and criticism, it is clear that the experience of evaluation, of "constant comparison" occurs in families and in social domains as well - even parents/guardians can "inadvertently cooperate" with and replicate the prevalent cultural discourse regarding women (Zimmerman & Dickerson, 1994b, p.298).

Upon reflection, I now realize that I had numerous opportunities or "openings" to enter into deconstructive conversations with individual members which I could have utilized more fully. That being said, by the end of the "deconstruction session" the group members had come to the conclusion that our society's expectations of them were often unrealistic and often unfair. Sadly, they felt that their awareness of this and their determination to be true to themselves, to their talents and abilities etc. was constantly being challenged by the media, peers, and even their families. To me, this conclusion is evidence enough of the value of asking questions which attempt to deconstruct the power of context and circumstances.

Theme Three: Resistance and Hope

One of the original aims identified for this group was to bring forward hope. In order to do so it was first necessary to identify sites of resistance and to fully appreciate these heroic acts of taking a stand. The narrative therapist has faith that these sites exist based on their belief that there are always ways around the problem.

As described previously in chapter two, Michael White's micro map for a definitional ceremony was utilized in this group. One entire session was devoted to each

of the participants whereby I was able to engage in a reauthoring conversation with one member while the others, as the outsider-witnesses listened and observed. It was through these conversations that I was able to gain a greater appreciation for not only the influence and effects of the problem(s) the young women were struggling with but also for the personal qualities, abilities and other characteristics that were available to them. It was here that several acts of resistance were discovered.

Four out of the five young women participated in this intervention activity due to one member being absent for a number of sessions during this period. While the definitional ceremony overall lacked the power I'd hoped for, the reauthoring component to this process was invaluable.[9] Discovering unique outcomes tracing their history, making them more visible and then linking them to an emerging new story was challenging due to my inexperience, but very rewarding.

As previously mentioned documents of identity were created to both preserve and thicken the alternative story that was discovered through these conversations. These accounts of personal agency will also serve as a reminder of our conversations, which I hope brought forward exceptions to the problem story as well as new and preferred descriptions of identity previously restrained by the problem. Identifying and highlighting uncovered personal qualities, abilities, preferences, beliefs etc., and then putting them down on paper was, I believe, powerfully authenticating. The documents can be found in their entirety in Appendix G but I will endeavor to highlight examples of resistance in these alternative stories.

Susan re-named the problem "Fear" and shared how it had tried to interfere with her relationships and tired to convince her that her values were weak. Together we

[9] See discussion in "Challenges" for elaboration.

discovered how strong-mindedness together with Susan's belief that if she really wants to do something she can do it, assisted her to reclaim her life back from Fear. We also learned how Susan's skill of writing and the value she places on keeping promises and friendship assisted her and could be called upon in the future.

Amber shared a tragic story of loss at the hands of HIM and his allies, guilt and depression. Whittling away her confidence and self esteem, Amber was unable to see any worth in her self. Today, thanks to her critical astuteness, determination and resiliency, Amber is eager to "prove them wrong" (i.e. the problem's versions of her) and be successful at reaching her goals. Amber identified many wants and dreams and was pleased to discover that hope is always with her.

For **Lucy** it was the influence of "Low Self-Confidence" that caused her to second guess herself, miss out on activities she enjoyed and being with friends. It put her down and brainwashed her to not believe or trust herself. On more than one occasion however, self-motivation encouraged Lucy to take a stand against this villain. In retaliation she poisoned Low Self-Confidence with a special serum of her most potent qualities: nice, smart, caring and funny, weakening its power over her. This allowed her to call up her friend and invite him to a movie, attend the group and share her story.

It was "The Critic's" tricks and lies that had **Colleen** believing she wasn't good enough. It put her down and criticized her appearance. It even teamed up with worry on occasion to concern her with what other people might think of her. Interestingly, Colleen discovered that there is a positive aspect to The Critic- a positive voice which can over power the negative one and encourage Colleen to work harder. With the assistance of strength and resiliency, Colleen has been able to ignore the negative voice of The Critic

when she is at school, working, or spending valuing time with friends or family. Qualities like strong, diligent, hard working and persistent assist her to stay focused on what is important to her.

In each of these alternative stories the protagonist is not the problem but rather a courageous young woman who has taken a stand. I believe hope was brought forward in each of these stories. Themes of resistance and hope appeared again in our 11th group session when the young women shared their second piece of artwork and described their relationship with the problem at that time.

In our 10th group session the art work pieces created in the first round were returned to group members who were asked to review and reflect on them. For the second round, the young women were encouraged to consider whether their relationship to the problem had changed at all in the course of the group (since the last picture was created). They were then asked to create another picture to illustrate their current relationship to the problem that they had identified previously.

Lucy's picture depicted herself and friends on a boat cruise in Quebec where she had been for a school trip. To Lucy this trip was significant in assisting her to separate from Low-Self Confidence even further. The amount of confidence she found in herself surprised Lucy and allowed her to have fun and make new friends. She shared,

> "*...I was amazed at how much like confidence I had and when I came back my mom's all proud of me and she's all like 'I'm really glad you went and I'm happy that you had confidence...that you went and did stuff that you normally wouldn't do'*".

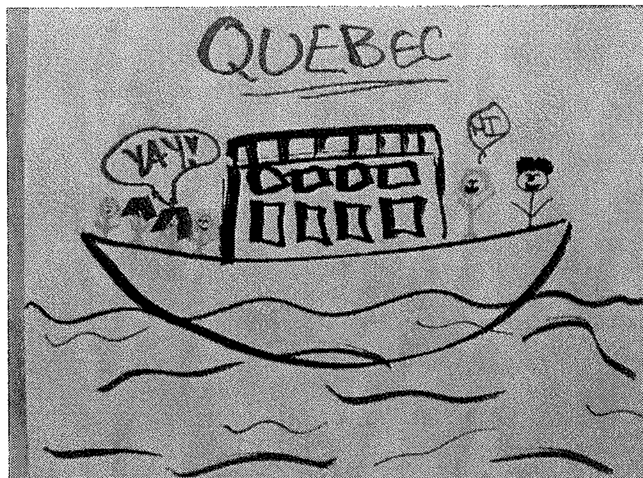

Figure 7. Lucy's picture from the second round.

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Amber's picture of a forest scene had two sides - a "dark side" with dark clouds and rain and a "happy side" with sunshine and birds in the sky. Amber shared that she enjoys spending time in nature where there is no one to compare herself to, no one to criticize her. For her, the happy side of the picture represents *"hope... I might have the courage to do what I want to do in life or whatever...believing in myself more".* For Amber the dark side represents the ongoing struggle against HIM that she anticipates she will have despite her resistance to his messages.

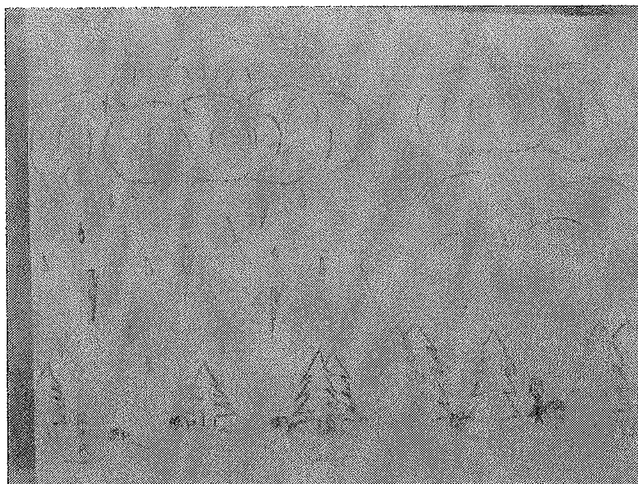

Figure 8. Amber's picture from the second round.

Jackie's picture was also two-sided with one side representing "his (HIM) side" and the other side being "her side".

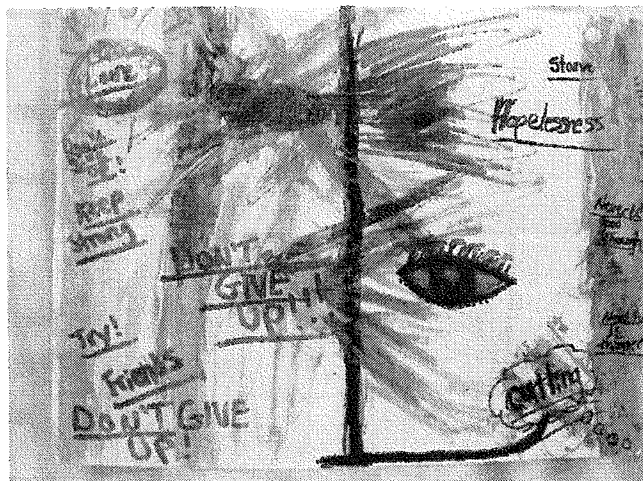

Figure 9. Jackie's picture from the second round.

In describing the piece she states,

> *"...even though the red slashes are there the sunbeams are still kinda showing through...so I've been able to push HIM, like he was more on this side but I've been able to push him back on this side and he's like getting farther and farther away".*

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Colleen's picture echoed our previous conversation (during definitional ceremony) regarding the competing voices of the critic. It also illustrates the internalized problem conversation she has with herself. Sometimes this conversation leaves her feeling defeated but at other times she is left feeling more confident in her strengths and abilities.

> *"...[S]ometimes I think I'm pretty and sometimes I really think I need to lose weight and I'm ugly and I think that will always be the same. There will always be a dark side."*

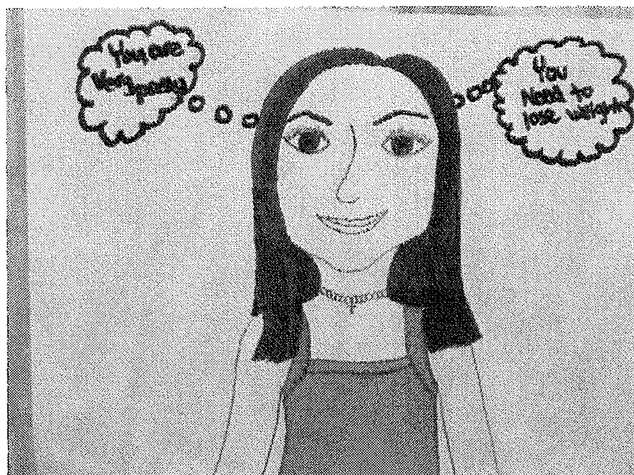

Figure 10. Colleen's picture from the second round.

When asked about "hope" later in the discussion, M shared her belief that having confidence in herself i.e. "you are pretty" is a hopeful message.

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Susan, our very poetic group member, shared that her art piece was in some ways a dedication. She wanted to recognize the assistance she had received from others in fighting against the problem. *"... [A] lot of people helped me a lot through helping myself in getting better and stuff like that."*

Figure 11. Susan's picture from the second round.

The poem on the pencil drawing of a woman resting her head on the chest of a man is as follows:

"I may be bleeding but I'm still walking.
I'm limping but I'm running.
I've got stitches, I've got scars
But somehow I'm walking, somehow I'm running
And I'm healing because of you."

To conclude, it would appear that participating in the group had some impact on group members' relationship with the problems they had come with. All group members related that they felt more distance between themselves and the problem. All felt that there were times when the problem had less influence in their lives, times when they felt more in control.

Unfortunately, despite some evidence of movement away from the problem-saturated stories of their lives to more preferred versions, the theme of "constant struggle" also appears in some of the pieces. I believe this speaks to the cruel and oppressive nature of their struggles.

Summary of Evaluation Results

Pre and Post-Intervention Measure of Self-Esteem (SERS)

As previously reported, group members completed The Self-Esteem Rating Scale (SERS) at the pre-group meeting and again in our final group session. The scores from these questionnaires are presented in the table below.

Table 2

A comparison of pre and post group scores on the Self-Esteem Rating Scale (SERS).

GROUP MEMBER		PRE-GROUP SCORE	POST-GROUP SCORE	DIFFERENCE
A	JACKIE	-11	13	24
B	SUSAN	10	19	9
C	COLLEEN	-32	-7	25
D	AMBER	-60	-14	46
E	LUCY	9	29	20

Note: Scores on the SERS can be negative in value.

Group mean

The pre-intervention group mean was –16.8

The post-intervention group mean was 8.0

Difference: 24.8

Group median

The pre-intervention group median was -25.0

The post-intervention group median was 7.5

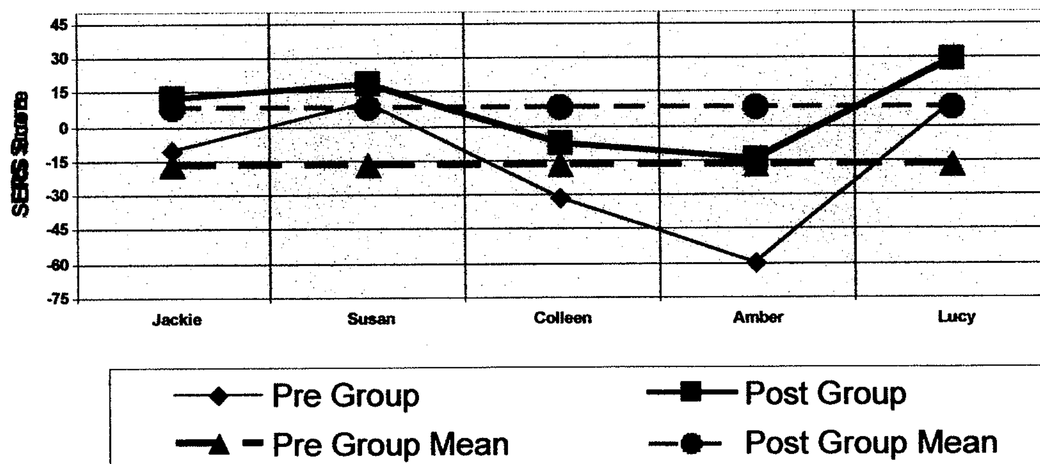
Difference: 32.5

Range

For the pre-intervention results the range of scores was –60 to 10.

For the post-intervention results the range of scores was –14 to 29.

Figure 12. A comparison of individual and group mean pre and post intervention scores on the Self-Esteem Rating Scale (SERS) questionnaire.



Discussion. For all group members a positive change in self-esteem was observed when pre and post-intervention scores on the SERS were compared. Even for Susan and Lucy, whose scores started in the positive range, an increase was noted. Of particular significance is the change in scores for Colleen and Amber who had considerably lower scores than the rest of the group on the pre-intervention questionnaire. Their post-intervention scores while still negative showed the greatest increase.

Group Process and Impact Evaluations

Qualitative evaluation methods were used to gather feedback from group members regarding the group process and its impact on group members' lives. A mid-group evaluation to assess process occurred in the second half of Session #5 and a final

evaluation to assess impact took place in the first half of Session #12 followed by the celebration).

Inspired by Deacon & Piercy's (2000) adaptation of evaluation tools used in participatory group events by UNICEF, the **mid-group evaluation** utilized a focus group format to provide members with a structured forum for discussion of the group's strengths and weaknesses. Lisa Seymour (my group advisor) facilitated this evaluation session. She compiled and summarized the feedback, which included suggestions and then presented them to me for incorporation into future sessions. For a more detailed description of the process utilized please see Appendix J. Overall the feedback from group members at this juncture of the group was positive. A summary of this feedback is presented below.

Strengths

Good relationships with each other

Feelings and thoughts we share, I believe that makes us stronger (individually and as a group)

We all feel comfortable sharing our opinions and ideas

No one is judging us

Like that Karen takes part, doesn't observe, doesn't judge

Supportive of each other and very kind

Like the check-in/check-out because it sort of lets us know how others are feeling.

Weaknesses

Time – need more time – length and number of meetings

Sessions could be a bit longer – beginning sooner or ending later

Time too short - feels like we're only here 10 min. - goes so fast

Suggestions

Add a half hour maybe

Run group from 6-8 pm instead

Meet two times a week

Extend sessions until 9pm

Party together outside at the end

This feedback was helpful as it let me know that group members were starting to feel comfortable with the group and that my participation was accepted. In the following session a discussion regarding the suggestions took place and as a result it was agreed that the group would run for 2 hours instead of 90 minutes for the remainder of the sessions. It was also agreed that time would be set aside in a future session for group members to plan a celebration to mark the group's end.

To gain a sense of what the group members thought about the group overall and whether the group had an impact on their lives, a **final group evaluation** questionnaire was created and distributed in the last session. The group evaluation document as well as a summary of all the responses can be found in Appendix K. An effort to summarize these responses follows.

Most group members indicated that creating pictures to represent their relationship to the problem was an enjoyable and helpful activity. Group discussions were also described in this way. One group member stated that she liked the guided imagery activity, another identified participating in this exercise as being the least helpful of the activities. With regards to suggestions for future groups, two members felt that more

games at the start to get to know one another would be helpful. I have incorporated this into my own recommendations as I too felt that this was a shortcoming. Other useful information for the planning of future groups of this nature can be found in the members' responses to questions pertaining to group size, duration and frequency.

Group members all chose positive statements to describe the group. These statements in addition to responses pertaining to the group environment spoke to the group's safe and supportive milieu. All group members indicated that they felt accepted, most felt like their voice was heard (one neither agreed nor disagreed), and all responded that the group experience was meaningful. It appears from the responses to question # 5 concerning any changes noticed in themselves since coming to the group that each individual was impacted in some way by the group experience. All identified a positive change of some kind. Two members related that they felt more confident in themselves, one expressed feeling less alone and another indicated that she felt more hopeful. Four of the five members shared that they had learned something new about themselves. I was somewhat disenchanted but not surprised to learn that only three members indicated that they felt they had regained some control over their life that the problem once had. Perhaps an additional question regarding the perceived reason for this could have been added for additional clarity. It remains unknown for example whether this can be attributed to a failure of the intervention, inexperience of the facilitator, the incessant nature of the problem or a combination of the above. Despite this disappointing response, I believe that the evaluation as a whole demonstrates that the group was a positive, meaningful experience for group members and I am confident that while some individuals may continue to struggle against their problems all will move forward from the group

encounter feeling a stronger sense of personal agency and more assured of their self-knowledge.

CHAPTER FIVE

Summary of Practicum Experience

Discussion of "Our Voices"

Group Dynamics and Processes

With very limited group work experience behind me, beginning a group of this nature proved to be a daunting and stress provoking task. In hindsight, I believe my capacity to be attuned to the dynamics and processes occurring within the group were at times hampered by my own performance anxiety. Thankfully time spent reflecting on group sessions afterwards as well as discussing issues and concerns with my group advisor proved to be helpful in this regard.

Toseland and Rivas (2001) identify four dimensions of group dynamics as being of particular significance. I will utilize these to structure the following discussion.

1. communication and intervention patterns
2. cohesion
3. social control mechanisms
4. group culture

Communication and intervention patterns. In preparing for the group I had been informed by both the literature and discussion with colleagues of the potential for inappropriate communication patterns when working with a group of adolescents (e.g. talking at the same time, cutting each other off, not listening etc.). I was pleasantly surprised to discover that there was minimal concern in this area. While group members were at times understandably somewhat preoccupied with their own lives and stories, for the most part all were kind and respectful to others. Interpersonal tension if it did exist

between group members was never noticed. In fact, I never heard a single criticism uttered toward another person or regarding the process.

Competition was never overt although it is likely given the powerful presence of constant comparison in the lives of the young women that a peeking order of sorts may have existed in individual group members' minds. This may for example have been based on age, maturity, comfort level with speaking or even perceived body weight. More apparent throughout the group was a feeling of commonality. Despite some differences, the group was quite homogeneous with regards to group members' experiences. Here they very much aligned with one another. This factor likely reduced some of the anxiety members may have experienced at the beginning (i.e. in questioning whether they would fit it, be liked and accepted). The exception to this was Lucy's experience after the first session as discussed previously. In her case, because she initially perceived herself as being different in a very significant way her anxiety was more pronounced.

Throughout the group not everyone interacted with equal valence. During times of discussion, some group members were more silent than others. This was particularly evident early in the group and therefore could be attributed to members feeling less comfortable and safe at this stage of the group. Later in the group I would attribute this same dynamic more to members' thoughtfulness and reflection.

I believe the structured nature of many of our sessions and my role as facilitator contributed to a feeling of equal opportunity with regards to participation and involvement. Many sessions for example were "leader-centered" with group members responding more to me than to each other (Toseland & Rivas, 2001). This occurred both

in the early stages of group development and later during the definitional ceremony sessions. At times this manifested itself in "go-a-rounds" or a "round-robin" whereby everyone was encouraged to respond to a particular issue or question and everyone always did. At other times I was more of the central figure with communication flowing between myself and individual members. Despite my initial desire that the group be more "group-centered", I believe that leading the group at times was both necessary and beneficial. It allowed me to structure the group's time more effectively, ensure everyone's voice was heard and provide me the opportunity to try and link group members' lives in meaningful ways.

Once the group was more established the leader-centered pattern often turned into a more group-centered one with group members spontaneously interacting with one another to provide feedback, request clarification or to share how someone's comment resonated with them. Because I often participated in the discussions and activities, not as a facilitator but as a participant who shared similar experiences, I believe a common ground was established and the power imbalance minimized.

As mentioned previously in this report two of the group members were friends prior to starting the group. While there was some initial concern regarding the potential impact this subgroup could have on the overall group dynamics, I think this was minimized to some degree by the fact that their friendship never really entered into the discussion. During the time that the group ran both individuals were quite busy with school and other activities and therefore rarely spent time socializing with one another. Overall, I do not believe this subgroup dramatically changed interactional patterns within the group.

Cohesion. One dynamic that I was not entirely prepared for was the possibility for artificial conformity. This tendency for group members to seek concurrence and change their opinions because they feel pressured to conform to the dominant perspective of the group has been referred to as "group think" (Gitterman & Wayne, 2003). I became suspicious about this dynamic occurring during the group's very early discussion regarding the struggles that had brought them to the group and again when they agreed to name the problem "H.I.M". I wondered at that time if certain group members truly identified with the name chosen or if they simply felt pressured in some way to agreed to it. I think these suspicions were warranted given that as the group progressed, individual group members chose to give alternate names to the problem they were struggling with. I noticed greater variety of opinions suggesting that individuals felt more comfortable expressing their own views and worried less about conforming. I think this alone speaks greatly to the group's cohesion.

Additional evidence for the group's cohesion can be found in the group progress and impact evaluations. As reviewed earlier, even in session #5 when the mid group evaluation was completed, group members identified feeling comfortable sharing their thoughts and feeling and described the group environment as a kind, supportive and non-judgmental. Of note here is the fact that group members given the nature of their struggles were often expressing feelings of inadequacy or "not measuring up" – a feeling one tends to keep to oneself. Similarly, in the impact evaluations done at the end of the group, all members agreed that the group was a safe and supportive environment and indicated that they felt accepted. I believe it was this feeling of acceptance despite differences that allowed Lucy to return to the group after the first session. If rejection

and disapproval had occurred or been perceived, without a doubt we would have lost Lucy as a member – and possibly others.

Social control dynamics. Group rules were created by group members in the first session as discussed previously. Created and clearly articulated by group members, these became the norms followed throughout. There was never a need to challenge anyone's attitude or behavior in the group. I can only assume that the members chose to adhere to the rules because they saw them as important and meaningful to their participation and to the group's success as a whole. My contribution to the rules discussion was to question whether the group felt attendance and punctuality were important. All agreed that this was necessary for the group's functioning – but this may have been partly due to the fact that I identified these as my expectations in pre-group meetings.

I never felt the need to control or dominate the group; instead every effort was made to ensure that group members felt they had equal status to other group members by encouraging equal participation and ensuring that everyone's voice was heard. If, as discussed previously, group members perceived there to be hierarchies in the membership, I do not believe this was a lasting dynamic as the group progressed.

Group culture. According to Toseland and Rivas (2001, p. 86), group culture "refers to values, beliefs, customs, and traditions held in common by group members". Due to the fact that no time was afforded to learning about individual group members' origins, cultural backgrounds etc. neither similarities nor differences in these areas were discussed. That being said, in hindsight I wish I had explored group members' cultural backgrounds further in an effort to learn more about the potential impact of these origins on their identities. I suspect, for example, that the group member who is a visible

minority experiences additional unique challenges of discrimination that the other group members would not.[10]

As the group developed and additional sharing occurred, I believe the group members discovered that they did possess similar values and beliefs. As young women living in Canada, they also shared a common cultural context and thus were exposed to the same media influences and unrealistic expectations regarding thinness, beauty and success. Because these young women faced similar challenges group culture evolved quite quickly. Any diversity of life experiences of individual members was accepted and appeared to be overshadowed by the powerful influence of the dominant societal values and beliefs that all experienced.

Challenges and Successes

Challenges. Facilitating a group with minimal experience is an endeavor which lends itself to challenges. The first challenge encountered was that of recruitment. As discussed previously this was unexpected and time consuming. As a novice to group work other challenges I experienced were: knowing when to steer and when to let the group members take the wheel, being mindful of group dynamics and processes, juggling my dual role as facilitator and participant and overcoming my own performance anxiety.

Since I was almost equally inexperienced in narrative therapy, implementing some of the intervention activities was also tricky. During the first definitional ceremony session for example, my own insecurity had to have been apparent. I was quite concerned with how the process would go and was worried about how the group would respond to the activity. I was relieved when Susan volunteered to go first but my awkwardness remained. Today I am satisfied with this first attempt at having a

[10] Please see "Recommendations" at the end of this report pertaining to cultural considerations.

reauthoring conversation while the other group members observed and believe I became more skillful with every attempt. Unfortunately, in the second stage of the definitional ceremony when the outsider witnesses were to respond, I found the young women were quick to compare Susan's story with their own and appeared to have difficulty speaking about what they had heard and came to appreciate about her. I eventually became involved by facilitating the discussion to elicit some of the kinds of responses I was looking for. I anticipated that I may have to play this role to ensure that the re-tellings were linked back to the person at the centre of the ceremony, but was not prepared for the challenge of switching gears (i.e. from interviewer to group facilitator). Again with each attempt the process did become more comfortable for all involved. The combination of this and the positive feedback received from group members about the process increased my confidence which in turn I believe decreased the group members' anxiety about participating. So while the group members and myself found the additional structure cumbersome initially, we all agreed that it was a worthwhile process in the end.

Creating the "documents of identity" for each group member after their participation in these definitional ceremonies was also much tougher than I expected. Endeavoring to create an account of personal agency that would adequately capture what had been said although an enjoyable and rewarding experience was not easy. However, I am pleased with the end products and believe that their value stands out as an accomplishment I can be proud of.

In addition to the challenges resulting from my lack of experience and skill were those which arose in the life of the group. I have already spoken about Lucy's experience of the first session and her feeling that she did not belong. Because this had occurred, I

became somewhat hyper-sensitive with regards to her comfort level for the remainder of the group and found myself on more than one occasion wondering how something said in the group would resonate with her. For example, when one group member shared the belief that her weight loss resulted in people (especially guys) being more interested in her and liking her more, I was panic stricken. In the discussion that followed I attempted to deconstruct this belief and felt the group did a great job of finding other qualities to explain what this individual perceived as being a renewed interest in her. I felt comfortable with this discussion until Lucy did not show for the next session – then the panic returned. Thankfully, her absence was due to illness not avoidance and she attended the remaining sessions without issue.

The time of year that the group was run created other kinds of challenges. As the school year was coming to an end – school trips, performances, exams etc became potential conflicts with group attendance. Similarly, the summer weather had arrived and with that likely came the temptation to skip group and do something fun outdoors. For one group member who was very involved in extracurricular activities, this became a concern as she missed several sessions. Her absences could have impacted the group's functioning as a whole. However, the group dynamics were such that understanding and acceptance for this individual's situation appeared to outweigh any concern or resentment that may have existed. I am pleased to report that despite seasonal distractions with the above exception and the occasional illness, attendance remained quite consistent.

Successes. The group members' commitment to participating as demonstrated by their attendance, the development of group cohesion, the notable increase in all SERS

scores and the overall reported satisfaction with the group speaks to this groups' success. More specific successes worth mentioning are as follows:

- *Externalizing the Problem*

Assisting the group members to label, objectify and even personify their struggles by engaging them in externalizing conversations was an effective means to help them differentiate problems from themselves. I believe doing so was the spark for the fire that would become hope. With new options for thinking and talking about the problem came additional possibilities for consideration and new, preferred stories about their identities.

The artwork enhanced the externalization process by putting group members' struggles in visible form. The time allotted for group members to create their piece also allowed individuals time to reflect on their experiences without having to consider what other's responses might be. The art brought group members' experiences to life and allowed for an audience to reflect on its meaning. I believe the artwork was compelling and stimulated the group's discussions particularly around the influence of societal values and expectations.

- *Environment*

I believe the group milieu contributed to the young women feeling comfortable talking about their struggles in a candid and sincere manner. The stories shared were heartfelt and meaningful. The significance of these tellings should not be underestimated as it is not possible to know what sort of lasting impression they had on group members. Not only did the group offer space to share thoughts, feelings and experiences, but also to examine and challenge the dominant cultural norms, values and expectations that impacted so greatly on the lives of these young women.

- *Blending of Roles*

I would identify my primary role within the group as being that of facilitator. However, at times I was also very much a participant, partaking in the intervention activities just like the others. As facilitator I believe I was able to maintain a stance of "not-knowing" (Anderson & Goolishian, 1992) by viewing myself as the curious questioner rather than an expert. I would agree with Dean (1998, p. 26) that my "expertise [was] exercised through providing a context" in which multiple stories could emerge and be heard.

As a participant I added my story and was open and eager to hear the experiences of others but sensitive and attentive to its potential impact on group members and the group process. Unlike in more traditional approaches to group therapy where the relationship between group facilitator and participants is hierarchical, I think our relationship was based on collaboration. I was surprised by how natural it felt to blend these roles and would attribute this to working within a narrative therapy framework.

Narrative Group Work and Social Work Practice

As a direct result of this practicum experience I have a greater appreciation for and more confidence in the value of group work. It is clear to me now that group work in general has oodles to offer including a tremendous opportunity for connection, support and the enhancement of well-being. As a means to share experiences, provide support, improve self-understanding and interpersonal skills, group work is undeniably a valuable therapeutic intervention. Incorporating narrative therapy into this work for me made the experience that much more meaningful and gratifying.

From the narrative perspective, therapy is about reconnection. It is understood that people seek out and attend therapy when they feel disconnected. For individuals facing similar struggles who may have felt isolated and perhaps even silenced by these struggles, the group provides a marvelous opportunity for connection. It is also an ideal context for the discovery of new stories and for "finding gateways to other territories of life" (White, 2003). The sharing of individual stories with a built-in community of support is a wonderful way to begin this process of discovery. Narrative therapy it seems is particularly amenable to group work.

The group is also a great environment to challenge internalized problem conversations. Here, the voices of the participants are privileged, not the voice of the problem. Members can collectively embark on a journey of exploration for the origin of these debilitating conversations in the larger cultural discourses and begin to critique the powerful societal messages that have dictated and influenced their identity. Becoming aware that these conversations are not unique to an individual but rather common to many must be extremely authenticating. From a narrative perspective, not talking about this cultural context would be unethical. As a social worker, I'd like to think this belief is shared by my profession.

The compatibility between narrative therapy and social work practice is clear. I believe the values, beliefs and understandings which underpin narrative therapy are congruent with the core ethical principles rooted in humanitarian values to which all social workers should aspire. Self-determination and social justice, the first two of these core principles as articulated in the new Canadian Association for Social Workers Code

of Ethics (2005) are a distinguishing feature of and fundamental to social work as a profession. Similarly, I believe these are at the heart of narrative practice.

The narrative therapist will query: "what are the larger cultural discourses that support this problem". Similarly, when considering the "person-in-environment" (social work's practice domain), a social worker should not ignore the macro level and therefore must consider the socio-political and cultural environment in which problems arise. Both recognize the complexity of the social context and the powerful influence that dominant societal norms and expectations have on people's lives and on their identities. Despite this recognition on the part of the social work profession, I would argue that far too often in practice, we as professionals fall prey to the "vast array of psychological discourse which supports pathologized and totalized descriptions of a person-identity-as-problem" (Madigan, 1996 p.55).

I fear that despite good intentions to help those who consult with us we may unknowingly contribute to the privatization of problems within people and in the process lose our sense of collective responsibility. Madigan (1996, p. 58) writes:

> *"If our therapeutic discourse is allowed to go unchecked we might be in danger of promoting and recreating the very contexts which have assisted the problem stories we are trying to eliminate."*

Recommendations

1. Understand the theory behind the approach. Prior to engaging in the practice of narrative therapy one must make some effort to understand and appreciate the theoretical foundation on which narrative therapy is grounded. To separate narrative practices from this foundation would be naïve and limiting.

2. Be mindful of the time of year when running a group for adolescents. As the end of the school year approaches adolescents not only have more commitments (e.g. exams, final concerts/productions) but also may be more inclined to spend their free time outside.
3. More "ice breakers" and trust/relationship building activities. Time spent on this early in the group would be a wise investment. Group members should feel like they know the people they are with not just their problems.
4. Run the group for a longer duration with greater frequency. Two hour sessions weekly for a minimum of 16 weeks would be my recommendation. This would allow for the possibility that externalizing conversations might need to be quite extensive. It would also allow more time to anchor alternative stories.
5. Add an experienced co-facilitator. A co-facilitator model should be considered. Perhaps one facilitator could be group work focused and the other could be experienced in utilizing a narrative approach to therapy. I believe a co-facilitator's ideas, skills and energy could have enriched my learning and also contributed in very meaningful ways to the group process. With two facilitators the group could have been slightly larger and some of the challenges I experienced could have been minimized. I would also not rule out the possibility that one of the facilitators be male.
6. Allow sufficient time to attend to internalized problem conversations. One must remember that problems take cultural ideas embedded in the way we think and turn them against the person.

7. Reflexivity. Reflecting on the experience and paying attention to our own internal dialogue is important. Asking ourselves questions about our questions and therapeutic beliefs can enhance accountability to the group and allows the therapy to remain flexible.
8. Include previous group members in future groups. Ideally, several groups of this nature would be run with veteran group members eventually taking a more prominent role in leading them. At the very least, the insider knowledge from one group could be shared (perhaps in the form of a video tape) with the next. Creating an archive of this insider knowledge overtime would be invaluable and might move the group to establishing a community of concern.
9. Engage in issues of culture. Cultural considerations are relevant to the discussion of body and weight issues. In deconstructing the social context of eating issues for example, one must be mindful of the reality that different women might have different relationships with dominant norms, values and traditions depending on their culture and family of origin (Tamasese, 2001). Exploration and acknowledgement of these differences would be appropriate. As well, in the case of the white facilitator, she must acknowledge and address her position of privilege in which she stands in relation to women of other cultures.

Conclusion

I believe that the young women who participated in "Our Voices" benefited from the group experience. If attending the group in any way prevented these young women from taking a journey down a very treacherous road then the intervention was a success.

While this outcome and the specific impact of the intervention on individual group member's lives remains unknown I am confident that the overall experience was meaningful in some way for them.

For myself this practicum was transformative. As an introduction to group work and to narrative therapy the experience was very educational and extremely rewarding. It fostered in me a desire to become even more knowledgeable about the practice of narrative therapy and to consider incorporating more group work into my own practice.

A narrative therapeutic approach was well suited to working with these young women and their struggles with body and weight issues. Group work with its emphasis on mutual explorations and discoveries was very compatible this approach. The combination is a promising intervention for a variety of struggles and well worth exploring further.

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APPENDIX A

GUIDELINES FOR LISTENING GROUP

- Listen very carefully to the story of the person at the centre, especially for how it relates to your own experience.
- Be curious about the developments in this person's life.
- Notice any expressions which catch your attention.
- Notice any images (of the person's life, identity or the world more generally) that touched or moved you in some way.
- Notice what it is like to hear the conversation and be prepared to answer questions about why these expressions and images struck a chord for you.

QUESTIONS TO GUIDE YOUR REFLECTIONS:

1. What has it been like for you to hear ______'s story?
2. What stands out to you as you listened? Can you say something about why this stands out to you?
3. What expressions or images touched, moved or stood out to you as you listened?
4. What did these expressions suggest to you about ______'s purpose, values, hopes, dreams, and commitments?
5. What is it about your own life that accounts for why these expressions caught your attention?
6. Did any of the things ______ said make you think differently about your own life?
7. In what way will the conversation you witnessed impact on your own life? What might you think differently about? What might you do differently from now on?

APPENDIX B

"Our Voices" Information Package

Head Office
175 Mayfair Avenue
Winnipeg, MB R3L 0A1
Telephone: (204) 477-1722
Fax: (204) 284-4431
E-Mail: info@mys.mb.ca
URL: http://www.mys.mb.ca

❑ **Satellite Office**
226 St. Mary's Road
Winnipeg, MB R2H 1J3
Telephone: (204) 477-1722
Fax: (204) 949-4776

❑ **Kisewatisiwin Program**
23 Nickel Road
Thompson, MB R8N 0Y4
Telephone: (204) 677-7870
Fax: (204) 778-7778
E-Mail: mysnorth@mys.mb.ca

❑ **Northern APH Program**
Box 10610
Opaskwayak, MB R0B 2J0
Telephone: (204) 627-1460
Fax: (204) 627-1461
E-Mail: aph@swampycree.com

A United Way Member Agency

March 4, 2003

Dear Colleague:

RE:

OUR VOICES: A GROUP FOR YOUNG WOMEN STRUGGLING WITH BODY AND WEIGHT ISSUES

I am still accepting referrals for this group. It will run from April 8th - June 24th (Tuesday evenings from 6:30- 8pm). Depending on the number of referrals a second group may be offered on Thursday evenings.

REFERRAL CRITERIA:

1. Young women ages 14-16. (interested 13 and 17 year olds may also be accommodated)
2. Young women who do NOT meet DSM IV criteria for an eating disorder but who nevertheless struggle with body and weight issues.
   These issues may include:
   - -body dissatisfaction
   - -food and weight preoccupation
   - -feeling fat
   - -fear of becoming fat
   - -unhealthy weight loss strategies
3. Young women believe these issues to have had an impact on their ability to live a full and pleasurable life.

BENEFITS:

1. The opportunity to share stories in a safe, supportive environment.
2. Develop different relationships with the problems in their lives.
3. Move from stories about self and life that are limiting to stories that are more open and preferred.

4. Strengthened sense of person agency and self knowledge.
5. Meet new friends.

FORMAT:

1. Closed groups with a maximum of 7 young women in each.
2. Talking, sharing, storytelling and art.

REFERRAL PROCESS:

1. Referring worker contacts therapist, **Karen McKim @ 949-4771** to discuss potential group member (initial screening).
2. Referring worker faxes completed referral form to Karen @ 949-4776.
3. Interested participants can also contact Karen directly.
4. Karen will contact interested participants to schedule a pre-group meeting.

PRE-GROUP MEETING/SCREENING

1. Karen will meet with the young woman and her parent(s)/guardian to provide additional information about the group.
2. Karen will also meet with the young woman individually for part of this meeting.
3. The young woman will complete a questionnaire to complete the screening process.

LOCATION

MacDonald Youth Services' satellite office
226 St. Mary's Rd.

Sincerely,

Karen McKim B.A., B.S.W.

OUR VOICES: A GROUP FOR YOUNG WOMEN STRUGGLING WITH BODY AND WEIGHT ISSUES

REFERRAL FORM

PLEASE RETURN TO: KAREN McKIM
MACDONALD YOUTH SERVICES
FAX: 949-4776

NAME: ______________________________

BIRTHDATE: ________________ AGE: ______

ADDRESS: ____________________________________

PHONE #: ________________

PARENT(S)/GUARDIAN(S) NAMES: _________________________

____

REFERRING WORKER: ____________________

AGENCY/SCHOOL: ___________________

PHONE #: _______________

FAX #: _________________

- WORRY ABOUT YOUR WEIGHT?
- DISLIKE YOUR BODY?
- TRY TO LOSE WEIGHT BY DIETING, FASTING, OVER-EXERCISING OR OTHER MEANS?

YOU ARE NOT ALONE!

MANY YOUNG WOMEN IN CANADA FEEL PRESSURED TO BE THIN AND STRUGGLE WITH BODY AND WEIGHT ISSUES.

IF YOU BELIEVE THESE ISSUES HAVE HAD AN IMPACT ON YOUR ABILITY TO LIVE A FULL AND PLEASURABLE LIFE...

SPEAK TO YOUR SCHOOL COUNSELLOR OR CALL KAREN @ 949-4771 AND ASK ABOUT *"OUR VOICES"* A GROUP FOR YOUNG WOMEN LIKE YOURSELF STARTING IN MARCH.

APPENDIX C

Advertisement for Local Teen Magazine

Mirror, Mirror

When you look in the mirror, do you like what you see?

As you are probably well aware, adolescence can be a very stressful stage of life. It is a time of trying to make sense of who you are, where you fit it and worrying about whether you are "normal". During this journey of identity formation, it is common to feel awkward or strange about your self and your body. Unfortunately, the daily onslaught of messages from parents, peers, and especially media about how you are *supposed* to look and act can leave you feeling overwhelmed and possibly even inadequate. This is the case for many young women today who feel like they don't measure up to society's messages concerning femininity and female beauty. Tragically, after evaluating themselves against some pretty impossible ideals, some young women will respond in unhealthy ways – seeing no alternative. These unhealthy responses can lead to problems referred to as "eating disorders" but they don't have to!

If you dislike your body, worry about your figure and have tried to lose weight by engaging in unhealthy weight loss strategies (excessive dieting, not eating, over-exercising, use of laxatives or diuretics, vomiting etc.)...YOU ARE NOT ALONE!

If you believe body and weight issues are impacting on your ability to feel happy and enjoy life and are interested in participating in a fun, supportive group for young women like yourself...

Speak to your school counsellor or call Karen @ 949-4771 and ask about "Our Voices". Groups are starting in March.

Informed Consent for Participation in *"OUR VOICES"*

What is "*OUR VOICES*"? It is a supportive group for young women who are struggling with body and weight issues. The young women who participate believe that these issues have prevented them from feeling happy and enjoying life. They are interested in reducing the power that these issues have had over them and their lives.

What are the benefits? Some of the potential benefits of participating include:

- The opportunity to share stories about self and life in a safe, supportive environment.
- Move from stories about self and life that are limiting to stories that are more open and preferred.
- Strengthened sense of self esteem and self knowledge.
- Meet new friends.

What is the group format? The group will involve twelve sessions and will run from __________ to __________ on _________ evenings starting at 6:30 p.m. The group sessions will include sharing stories, discussion, art and other fun activities. The group will take place at 226 St. Mary's Road.

As the parent or legal guardian of...

Name: ________________________________ **Date of Birth:** ________________

I understand that:

1. Information shared by group members will remain confidential, except in certain situations in which there is an ethical responsibility to limit confidentiality. Information gathered about the group may be published or presented however group members' names will never be used or revealed.

2. Group sessions will be audio recorded to facilitate supervision of the group worker. The tapes will be accessible only to those individuals involved in the supervisory process and will be destroyed upon completion of it.

3. Group members will be asked to complete questionnaires that are useful for clinical purposes.

4. Group members will be asked to participate in mid and post-group evaluations.

I have read the above information. By signing this form I give my informed consent for my child to participate in the "*OUR VOICES*" group.

Parent/Guardian ____________________________ **Date** _______________

Participant ___________________________ **Date** _______________

APPENDIX E: The Questionnaire for Eating Disorder Diagnoses (Q'EDD)

Please complete the following questions as honestly as possible. The questions refer to current behaviors and beliefs, meaning those that have occurred in the past 3 months.

Sex: (Please circle) Male Female

Age: _____________

School/Occupational Status: (Please circle)
Junior High or younger (specify grade:_______)
High School Freshman
High School Sophomore
High School Junior
High School Senior
College Freshman
College Sophomore
College Junior
College Senior
Not in School/Employed (specify:______________________________)

Race/Ethnicity: (Please circle)
Caucasian/White
African-American/Black
Hispanic /Latino/Mexican-American
American Indian
Asian American/Pacific Islander
Other: ________________________(specify)

Present height: _______ feet ________ inches

Present weight: _______ pounds

My body-frame is: small medium large
(Please circle)

I would like to weigh ________ pounds.

1. Do you experience recurrent episodes of binge eating, meaning eating in a discrete period of time (e.g., within any 2-hour period) an amount of food that is definitely larger than most people would eat during a similar time period?

   YES NO

   If YES: Continue to answer the following questions.

   If NO: Skip to Question #4 (on the next page)

2. Do you have a sense of lack of control during the binge eating episodes (i.e., the feeling that you cannot stop eating or control what or how much you are eating)?

   YES NO

3. Circle the answers within the two sets of **[bold brackets]** below that best fit for you:

   On the average, I have had **[1, 2, 3, 4, 5, 6 or more]** binge eating episodes a WEEK for at least

   [1 month, 2 months, 3 months, 4 months, 5 months, 6-12 months, more than one year]

4. Please circle the appropriate responses below concerning things you may do <u>currently</u> to prevent weight gain. If you circle yes to any question, please indicate how often on the average you do this and how long you have been doing this.

a) **Do you make yourself vomit to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

b) **Do you take laxatives to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

c) **Do you take diuretics (water pills) to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

d) **Do you fast (skip food for 24 hours) to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

e) **Do you chew food but spit it out to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

f) **Do you give yourself an enema to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

g) **Do you take appetite control pills to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

h) **Do you diet strictly to prevent weight gain?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

i) **Do you exercise a lot?** YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month
How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months More than a year

5. If you answered YES to "exercise a lot," please answer questions #5a, 5b, 5c & 5d. If you answered NO to "exercise a lot," skip to question #6.

5a. Fill in the blanks below:

I ____________________________ (types of exercise, e.g., jog, swim) for an average of ______________________ hours at a time.

5b. My exercise sometimes significantly interferes with important activities.

YES NO

5c. I exercise despite injury and/or medical complications.

YES NO

5d. Is your primary reason for exercising to counteract the effects of binges or to prevent weight gain?

YES NO

For the following questions, circle the response that best reflects your answer:

6. Does your weight and/or body shape influence how you feel about yourself?

1	2	3	4	5
Not at all	A Little	A moderate amount	Very Much	Extremely or Completely

7. How afraid are you of becoming fat?

1	2	3	4	5
Not at all	A Little	A moderate amount	Very Much	Extremely or Completely

8. How afraid are you of gaining weight?

1	2	3	4	5
Not at all	A Little	A moderate amount	Very Much	Extremely or Completely

9. Do you consider yourself to be:

1	2	3	4	5	6
Grossly Obese	Moderately Obese	Overweight	Normal Weight	Low Weight	Severely Underweight

10. Certain parts of my body (e.g., my abdomen, buttocks, thighs) are too fat.

YES NO

11. I feel fat all over.

YES NO

12. I believe that how little I weigh is a serious problem.

YES NO

13. I have missed at least 3 consecutive menstrual cycles (not including those missed during a pregnancy). YES NO

APPENDIX F

Self-Esteem Rating Scale (SERS)

NAME: ________________

This questionnaire is designed to measure how you feel about yourself, it is not a test, so there are no right or wrong answers. Please answer each item as carefully and accurately as you can by placing a number by each one as follows:

1 = Never
2 = Rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = Always

Please begin.

______ 1. I feel that people would NOT like me if they really knew me well.

______ 2. I feel that others do things much better than I do.

______ 3. I feel that I am an attractive person.

______ 4. I feel confident in my ability to deal with other people.

______ 5. I feel that I am likely to fail at things I do.

______ 6. I feel that people really like to talk with me.

______ 7. I feel that I am a very competent person.

______ 8. When I am with other people I feel that they are glad I am with them.

______ 9. I feel that I make a good impression on others.

______ 10. I feel confident that I can begin new relationships if I want to.

______ 11. I feel that I am ugly.

______ 12. I feel that I am a boring person.

______ 13. I feel very nervous when I am with strangers.

______ 14. I feel confident in my ability to learn new things.

______ 15. I feel good about myself.

______ 16. I feel ashamed about myself.

______ 17. I feel inferior to other people.

______ 18. I feel that my friends find me interesting.

______ 19. I feel that I have a good sense of humor.

______ 20. I get angry at myself over the way I am.

1 = Never
2 = Rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = Always

______ 21. I feel relaxed meeting new people.

______ 22. I feel that other people are smarter than I am.

______ 23. I do NOT like myself.

______ 24. I feel confident in my ability to cope with difficult situations.

______ 25. I feel that I am NOT very likeable.

______ 26. My friends value me a lot.

______ 27. I am afraid I will appear stupid to others.

______ 28. I feel that I am an OK person.

______ 29. I feel that I can count on myself to manage things well.

______ 30. I wish I could just disappear when I am around other people.

______ 31. I feel embarrassed to let others hear my ideas.

____ 32. I feel that I am a nice person.

____ 33. I feel that if I could be more like other people then I would feel better about myself.

____ 34. I feel that I get pushed around more than others.

____ 35. I feel that people like me.

____ 36. I feel that people have a good time when they are with me.

____ 37. I feel confident that I can do well in whatever I do.

____ 38. I trust the competence of others more that I trust my own abilities.

____ 39. I feel that I mess things up.

____ 40. I wish that I were someone else.

APPENDIX G

Documents of Identity

Document of Amber's Identity

Tragically, for several years now, the effect of H.I.M. on Amber's sense of self and on her relationships with others has been great. H.I.M. has not only prevented her from doing things she once enjoyed like attending parties and socials, but also, H.I.M. has consistently told her lies about who she is, how she looks and what she is capable of.

GUILT and DEPRESSION have assisted H.I.M. in the onslaught. Together these villains have used lies and other contemptible tactics to whittle away Amber's confidence and her self-esteem. Despicably, they have even gone so far as to deceive Amber into questioning her self worth causing her to hurt herself. This deception has run rampant for so long now that, sadly, it has blinded Amber from seeing that she has personal qualities she can still depend on. However, H.I.M. has not won the battle because RESILIENCY, a strong defender, has stepped into the ring and is ready to fight. This often unnoticed personal quality of Amber's has heard her calls of distress and will, together with some of her other qualities assist in the banishment of H.I.M. from Amber's life.

There was a time when H.I.M. teamed up with CONSTANT COMPARISON and used trickery to get Amber to compare herself to "super" models and other celebrities. Today thanks to her CRITICAL ASTUTENESS she is no longer fooled by the airbrushed images of so-called perfection and sees them for what they are, "plastic", "fake", unrealistic portrayals of real women. She won that skirmish but H.I.M. was clever and attacked from a different direction. H.I.M. now causes Amber to compare herself to other people in her life including her friends.

At one time, H.I.M. even persuaded Amber to "escape the world" and go with him and ISOLATION into hiding so that she wouldn't get hurt. Thankfully, H.I.M. and ISOLATION were unsuccessful in keeping her hostage for long. Amber did not enjoy this time alone with H.I.M. nor did she appreciate H.I.M.'s constant nagging voice; H.I.M. made lousy company and ISOLATION was boring. It was ultimately DETERMINATION that assisted in her escape from ISOLATION by telling her, "You can't escape the world, so get back in there and try and associate more!"

DETERMINATION is one of Amber's personal qualities that is ever present but often hidden by H.I.M. When Amber feels overwhelmed with negative, discouraging messages, it is DETERMINATION'S voice that will tell her that she CAN and WILL be successful in life. It says,

"PROVE THEM WRONG!" Without a doubt, DETERMINATION has been another strong supporter in Amber's battle with H.I.M. It has allowed her to become more independent in doing her schoolwork, do extensive volunteer work and has helped her achieve an 80% average despite H.I.M.'s attempts to sabotage this effort. DETERMINATION has also encouraged Amber to continue to develop her skills as a writer, musician, actor and an artist. Amber's Uncle Tom would recognize the significance of these personal achievements.

In good times and during the tough times HOPE is always by Amber's side. It tells her that she will overcome the struggle with H.I.M and encourages her to dream about and plan for her future. HOPE sometimes gets lost in the chaos that H.I.M. creates but once the dust settles, Amber can count on the fact that HOPE will never abandoned her but might be hidden in H.I.M.'s shadow. The fact that HOPE has resurfaced today is cause for celebration!

Amber has recently called upon her WANTS to fuel her efforts to stay strong and overcome H.I.M.'s influence. Her WANT to be free, her WANT to help people, her WANT to go to university and become a social worker or psychiatrist, her WANT to travel to New York, her WANT to return to Greece and her WANT to survive will give her the energy to hang on to HOPE.

Together, Amber's qualities of RESILIENCY, DETERMINATION, HOPE and her WANTS are a powerful force in the fight against H.I.M. It is these personal qualities that Amber can call upon and will be able to put it to work in further challenges to the fake authority of H.I.M.'s voice.

Because the truth is very disempowering of H.I.M., whenever he tries to harass Amber she will read this document to H.I.M. This will confront H.I.M. with his deceit and will provoke H.I.M. to take a back seat in her life

Document of Colleen's Identity

Until a few years ago, Colleen was a competitive tomboy who didn't concern herself with stylish clothes, hairstyles and make-up. It was only after her move to _____ that she started to pay more attention to her appearance. Her hairstyle has changed, she dresses differently and she wears make-up but she is still the Colleen she has always been. Colleen likes who she is today but sometimes THE CRITIC'S tricks and lies can make her feel like she isn't good enough.

THE CRITIC lives inside of Colleen and has had both negative and positive influences on her life. Sometimes it is a nuisance and sometimes it can be helpful. It is a real pest when Colleen is trying to get ready in the morning or when she is preparing to go out with friends. Showing, it's dark and ugly side, THE CRITIC puts her down and criticizes how she looks. On occasion, THE CRITIC has even called upon WORRY to assist in the badgering. It is WORRY'S job to concern Colleen with what other people think of her.

Despite THE CRITIC'S efforts to brainwash Colleen into thinking that she has nothing to offer, it has not succeeded in preventing her from living and enjoying her life. When Colleen is at school, working or spending valuable time with her friends and family, she is more relaxed and she is able ignore the negative voice of THE CRITIC. She doesn't allow this voice of THE CRITIC to disturb her when she is busy at work or concentrating on her schoolwork. STRONG, DILIGENT, HARD WORKING and PERSISTENT, some of Colleen's finest qualities assist her to stay focused on what is important to her. These are qualities that would be appreciated by Colleen's teachers, caregivers and by Roy.

Sometimes THE CRITIC'S influence in Colleen's life is more positive and empowering. These positive aspects of THE CRITIC can sometimes overpower the negative ones. It is THE CRITIC'S positive voice that tells Colleen to ignore the putdowns and encourages her to work harder. It tells her that if she tries, she will succeed and that she has the power to decide which voice to listen to. Anyone who knows Colleen, has probably been witness to her STRENGTH and RESILIENCY and knows she has this power.

Another of Colleen's qualities, COMPETITIVENESS, can assist her in the struggle against the negative aspects of THE CRITIC. Together with the qualities previously mentioned, COMPETITIVENESS will also be there to support Colleen in reaching her goals of obtaining an education, living independently, getting a job and someday becoming a lawyer. It is not surprising that Colleen has an interest in law as she has a very strong belief: "Everyone is entitled to justice". This belief in JUSTICE combined with Colleen's CARING, COMPASSIONATE NATURE and her NURTURING SPIRIT will indubitably be a valuable asset as she journeys through life.

Because the truth is very disempowering of the negative voice of THE CRITIC, whenever it tries to hassle Colleen she will read this document to it. By confronting THE CRITIC on its lies and on the petty nature of its claims, it is hoped that this will cause THE CRITIC to take a back seat in Colleen's life.

Document of Lucy's Identity

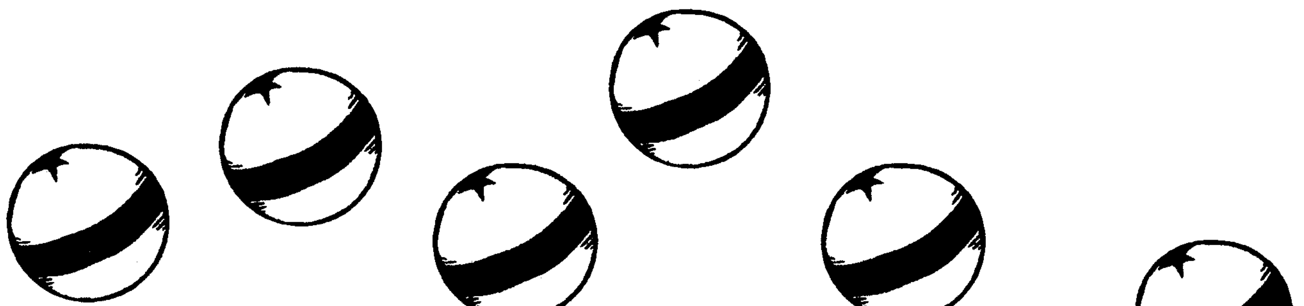
For a long time, Lucy has been lead astray by LOW SELF-CONFIDENCE. It is LOW SELF-CONFIDENCE'S influence that has caused Lucy to second guess herself, miss out on being with her friends, and not participate in activities she'd like to. While LOW SELF-CONFIDENCE continues to be a pain in the butt in certain aspects of Lucy's life, it has certainly lost some of the bullying power it once possessed. This is largely thanks to SELF-MOTIVATION, one of Lucy's impressive abilities.

On more than one occasion, SELF-MOTIVATION has encouraged Lucy to take a stand against LOW SELF-CONFIDENCE. This has required a good deal of spunk and a little bit of revengefulness. In retaliation for putting her down, brainwashing her not to believe in or trust herself and for preventing her from doing things she would like to do, Lucy poisoned LOW SELF-CONFIDENCE with a special serum made up of some of her most potent qualities: NICE, SMART, CARING and FUNNY. These are qualities that would be appreciated by her friends, family and new acquaintances but have weakened LOW SELF-CONFIDENCE considerably.

In its weakened state, LOW SELF-CONFIDENCE was no match for SELF-MOTIVATION'S powers of persuasion and failed to interfere when Lucy wanted to call up her friend, Chris and invite him to a movie. She JUST DID IT, he agreed and they had fun. Recently, LOW SELF-CONFIDENCE was also unable to prevent Lucy from attending the group or from sharing her story. In this situation she called upon SUPPORT and ENCOURAGEMENT to assist SELF-MOTIVATION in getting her to the group even though she wouldn't know anyone. The group is glad!

It could be expected that in future challenges, SELF-MOTIVATION would again show itself and assist Lucy to achieve her goals. SELF-MOTIVATION will also be there to remind Lucy of one her top priorities, ENJOYING LIFE. Since FUN, FRIENDS AND FAMILY are what she values, these are the things Lucy is prepared to fight for. Watch out LOW SELF-CONFIDENCE – Lucy's mind is a powerful and creative tool!

Because LOW SELF-CONFIDENCE is sneaky, whenever it tries to harass Lucy again, she will read this document so she is reminded of her powerful ability to motivate herself to JUST DO IT! As this power increases, it is hoped that the "LOW" will be erased and all that will remain is SELF-CONFIDENCE.



Document of Susan's Identity

In the past six months, even though it was "crazy hard", Susan was able to find the resources she required to consistently take a stand against THE FEAR. Despite THE FEAR'S tactics of persuasion, Susan continues to honor the promise she made to her boyfriend and now has the upper hand. She has taken determined steps towards reclaiming her life from THE FEAR who once held her hostage and made her do things she might not otherwise have done.

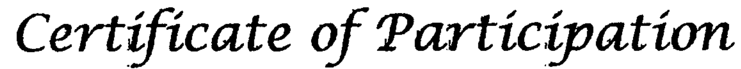
To accomplish this feat, Susan depended upon STRONGMINDEDNESS, a personal quality she can rely on in difficult times. It was STRONGMINDEDNESS that ultimately helped her to stand by her belief that IF SHE REALLY WANTS TO DO SOMETHING SHE CAN DO IT. Assisting STRONGMINDEDNESS in the fight were some of Susan's values. These included KEPT PROMISES and FRIENDSHIP.

Susan is the kind of person who thinks of others. She doesn't like to see others upset or angry (especially with her) and is the kind of person that others can rely on for support in times of need. These are qualities that would be appreciated by her friends and family. Knowing this about Susan, it should come as no surprise that she became protective when THE FEAR attempted to interfere in her relationships with others. Not wanting those she cares for to be exposed to the effects of THE FEAR, Susan called upon her values, KEPT PROMISES and FRIENDSHIP to assist STRONGMINDEDNESS in the battle.

When THE FEAR tried on several occasions to convince Susan that her values were weak and that she should continue to pay homage to the porcelain god she had decided not to worship any longer, it was Susan's skill of WRITING which stepped in. WRITING provided Susan with a much-needed distraction by encouraging her to put her thoughts to paper. To her surprise, this skill got her through many tough hours. While WRITING'S character has changed somewhat, it continues to be loyal and an important part of Susan's life. It could be expected that in future challenges, WRITING would be there for Susan.

Because the truth is very disempowering of THE FEAR, whenever it harasses Susan again she will read this document to it. By confronting THE FEAR with its deceit it is hoped that THE FEAR will take a back seat in her life.

APPENDIX H



This certificate is awarded to ______ ______ in recognition of her participation in OUR VOICES.

Her voice was a valuable contribution to the group and her beauty as a person will always be remembered and admired by those who have signed below.

Awarded on the 22nd day of June, 2003.

Signed: ____________________

____

____

____

____

APPENDIX I: List of Struggles Identified by Group Members

- Depression
- "Eating disorders"
- Dieting/counting calories
- Not measuring up
- Vomiting (purging)
- Starving/fasting
- Ashamed
- No confidence
- Self-conscious
- Annoyed with self
- Low self-esteem
- Self hate
- Drinking/drugs to cope
- Overcompensating in other areas
- The belief that "things would be better if I was different"
- Temptations
- Anger
- Constant comparisons
- Pathetic
- Pill popping
- Guilt
- Never good enough – need to lose weight

APPENDIX J

GUIDE FOR MID-GROUP EVALULATION

- Multicolored cards are used to encourage group discussion
- Each participant is given one red (pink!) card and one green card
- On the green card each participant will be asked to write one sentence (or more?) to describe one (or more) of the group's strengths
- Similarly, on the red card, she writes one sentence (or more?) to describe one (or more) of the groups weaknesses
- The facilitator collects and shuffles the cards and then reads them out one at a time, asking for comments and discussion
- After sufficient discussion, the facilitator rewrites each comment on a flip chart and repeats the process until all the cards have been discussed
- Then the facilitator asks the participants to group the cards into categories or common themes
- Next, each participant is given stickers labeled "1", "2", "3" and is asked to place them beside the weaknesses they believe are the most pressing (in numerical order)
- Once the most pressing weaknesses have been identified, blue cards are passed out and participants are asked to write their recommendations for addressing these weaknesses (e.g. what would be more helpful")
- Then as before, the facilitator shuffles the cards and leads a discussion of each - rewriting the recommendations of the flip chart. Again where possible, responses are grouped into categories or common themes.
- The information recorded on the flip chart will later aid the facilitator in summarizing the discussion and presenting feedback

APPENDIX K

Final Group Evaluation

Group Evaluation

Please take the time to share your thoughts and feelings about your participation in Our Voices. There are no right or wrong answers, and you won't be hurting anyone's feelings by saying what you really think.

Here is a list of some of the group activities and discussion topics that might help you to answer questions #1, #2 and #3:

- Check in and check out.
- Naming the problem and describing its personality.
- Creating pictures to represent your relationship to the problem.
- Telling your story.
- Listening to other group members tell their stories.
- Receiving a document summarizing your story and describing your identity.
- Participating in the guided imagery exercise.
- Group discussions on struggles we share, media influences, beauty, etc.

1. Which activity did you enjoy the most? Why?

____

____

2. Which activity did you think was the most helpful? Why?

____

____

3. Which activity did you think was the least helpful? Why?

____

____

4. What suggestions would you make to someone who is planning a similar group in the future?

____

____

5. Have you noticed any changes in yourself since you started coming to this group? If so, can you describe these.

____

____

6. A year from now, what do you think you will remember about the group experience.

____

____

7. What words would you use to describe the group?

____

____

8. What words do you think the other group members would use to describe the group?

____

____

9. I think 12 sessions was adequate.

1	**2**	**3**	**4**	**5**
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____

____

10. I think 2 hours was a good amount of time for each session.

1	**2**	**3**	**4**	**5**
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____

____

11. I think the group was a good size.

1	**2**	**3**	**4**	**5**
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____

____

12. I felt comfortable sharing my thoughts and feelings with the group.

1	**2**	**3**	**4**	**5**
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____

____

13. The group was a safe and supportive environment.

1	**2**	**3**	**4**	**5**
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____

____

14. I felt like I was accepted.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____________________

____

15. I felt like my voice was heard.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____________________

____

16. I feel like I have regained some control over my life that the problem once had.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____________________

____

17. The group experience was meaningful to me.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____________________

____

18. I have learned something new about myself.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

Comments: ____________________

____

SUMMARY OF RESPONSES

Our Voices

Group Evaluation

1. **Which activity did you enjoy the most? Why?**
   - "Liked doing the pictures because it was a good way to get our feelings out We could look back and see how much better the problem has gotten. Also when you talk about things you don't hear what you are saying, here we could see it."
   - "Group discussions because it really got us to listen and hear ours and others experiences and know that we are not alone and think the same things."
   - "I enjoyed the activity where we drew him and what he meant to us."
   - "I really enjoyed creating pictures. I also liked guided imagery."
   - "Group discussions on struggles we share, media influences, beauty etc."

2. **Which activity did you think was the most helpful? Why?**
   - "Receiving the document describing our identity was very helpful to me because if I am having a problem or thinking bad things I can read that paper and remember that I have strengths and can overcome the problem."
   - "I think the creating pictures part was the most helpful because it helps us to discover what and how the problem affects us inside us."
   - "Probably discussing HIM and how he relates in my life even though it was very difficult to open myself up."
   - "The most helpful activity was either telling my story or creating pictures."
   - "Creating pictures to show my relationship to the problem."

3. **Which activity did you think was the least helpful? Why?**
   - "I think every activity helped in a different way but I think the one that helped the least was the discussion of media influences. It helped lots just the least – no reason."
   - "I liked pretty much all of the activities."
   - "Where we had to draw HIM a second time because it was not like we could fix the problem in just two months but it did give me some hope."
   - "I really don't think anything wasn't helpful."
   - "Participation in the guided imagery exercise."

4. **What suggestions would you make to someone who is planning a similar group in the future?**
   - "Have a comfortable environment like this group."
   - More games for getting to know each other. Also that the sessions be longer maybe even for a longer period of time."
   - "Have a few activities so everyone is comfortable with each other, because I didn't feel like I knew the person just their problem. Also include guys because they deal with body issues too."
   - "Make sure your group dynamic is good like ours."
   - "Be open because everyone's there to listen, it would be more helpful."

5. **Have you noticed any changes in yourself since you started coming to this group? If so, can you describe these.**
   - "Yes, I feel like I can overcome my problems because we have identified them."
   - "I kinda of looked forward to coming each week (when I could make it) I feel less alone, and I know that I'm not the only one who has these problems."
   - "I have become more hopeful in life just Karen saying that I can succeed boosted my confidence because no one has every said that to me before."
   - "I have noticed changes in my confidence and ability to share."
   - "I learned a lot about myself and about my feelings."

6. **A year from now, what do you think you will remember about the group experience.**
   - "I will remember how it helped me become more confident realizing that I am(underlined) a good person."
   - "I will probably remember how everyone was so nice and that I regret having to miss so many sessions and how helped me to look at more positive things about myself."
   - "How greatly HIM impacted on my life."
   - "I would remember how much fun I had, the great people I have met and I would remember how I changed after the group."
   - "I will remember the people and the activities we participated in."

7. **What words would you use to describe the group?**
   - "Fun, easy, great."
   - "Encouraging, deep, meaningful, amazing people!"
   - "Nonjudgmental, accepting, friendly, and shyness."
   - "Kind, determined, respectful, strong."
   - "REALLY beautiful GIRLS."

8. **What words do you think the other group members would use to describe the group?**
   - "The same."
   - "I'm not sure I hope that they would say something about it helping them in some way, hopeful, nice, encouraging."
   - "Same as me."
   - "Probably the same ones I used."
   - "REALLY beautiful GIRLS."

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

9. I think 12 sessions was adequate.

2 PEOPLE SAID 4
2 PEOPLE SAID 3
1 PERSON SAID 2
Comments:
"I think we should have had more sessions."
"More sessions would have been nice but I'm not sure what is left to do."

10. I think 2 hours was a good amount of time for each session.

3 PEOPLE SAID 5
1 PEOPLE SAID 4
1 PERSON SAID 2
Comments:
"I think sessions should have been 2 _ hours instead."

11. I think the group was a good size.

4 PEOPLE SAID 5
1 PERSON SAID 3
Comments:
"We could have had 1 or 2 more people."
"Too many people would make things difficult."

12. I felt comfortable sharing my thoughts and feelings with the group.

2 PEOPLE SAID 5
2 PEOPLE SAID 4
1 PERSON SAID 2
Comments:
"I knew that no one would judge me."

13. The group was a safe and supportive environment.

4 PEOPLE SAID 5
1 PERSON SAID 4
Comments:
"I felt very comfortable."
"Everyone was respectful and cared."

14. I felt like I was accepted.

EVERYONE SAID 4
Comments:

15. I felt like my voice was heard.

1 PERSON SAID 5
3 PEOPLE SAID 4
1 PERSON SAID 3
Comments:

16. I feel like I have regained some control over my life that the problem once had.

1 PERSON SAID 5
2 PEOPLE SAID 3
2 PEOPLE SAID 4
Comments:
"I have new confidence that I didn't before."

17. The group experience was meaningful to me.

3 PEOPLE SAID 5
2 PEOPLE SAID 4
Comments:
"I had a lot of fun and learned a bunch."

18. I have learned something new about myself.

1 PERSON SAID 2
2 PEOPLE SAID 4
2 PEOPLE SAID 5
Comments:
"I learned that I feel very strongly about these subjects and that I am strong and I can fight back."
"I know myself better."