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THE FEASIBILITY OF DIALOGUE WRITING WITH PATIENTS WHO HAVE AN
EATING DISORDER

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2009

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The Feasibility of Dialogue
Writing With Patients Who Have
an Eating Disorder

ABSTRACT

This study emerged from the creation of dialogue writing, a new intervention for the treatment of eating disorders. A nascent intervention, the study investigated its feasibility as a form of treatment for eating disorders; specifically the study gathered data regarding the participant's experience with dialogue writing. The dialogue writing process involves writing a dialogue between the self and the eating disorder as personified in a character created by the participant.

Nine women receiving treatment for eating disorders at a clinic participated in a group setting in the dialogue writing exercise, which was administered by the groups' regular facilitator. Although the exercise was presented in a group setting, the process was completed individually. After the exercise, the women completed a questionnaire with open ended questions regarding the ease or difficulty of following the instructions, their experience during the exercise and the effect, if any, it had on their relationship to their eating disorder.

The findings of the research indicate the need for some alterations to the verbal instructions. Additionally, the intervention's ability to aid the participant in externalizing their eating disorder became evident. Issues of power and control in participants' relationships to their eating disorders emerged, as well as contradictions inherent in thought processes. Emotional responses were primarily mixed and varied for each client.

The study also showed the effectiveness of the intervention in engaging participants in their own process regardless of their stage in treatment.

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CHAPTER I

INTRODUCTION

This study examines the feasibility and potential usefulness of a new intervention called dialogue writing for the treatment of eating disorders. The exercise, developed by the researcher, uses creative writing along with externalizing techniques found in narrative therapies to guide participants through a dialogue between themselves and their eating disorder. The study asks: Are people with anorexia or a related binge eating disorder able to follow the dialogue writing process? What, if anything, do people learn about themselves and their disorder during the dialogue writing process?

While similar exercises have been developed, this specific intervention has not been studied; however, the usefulness of externalization and therapeutic aspects of writing in the treatment of eating disorders has been researched and shown effective. Dialogue writing developed from the research done in these areas. While the process of dialogue writing may be useful for a variety of populations, the exercise was developed specifically for the treatment of eating disorders because of discussions in the literature of the usefulness of engaging with the “voice” of the eating disorder in treatment.

According to the National Eating Disorders Association (NEDA), approximately 10 million women and 1 million men in the United States suffer from anorexia nervosa or bulimia nervosa. Both of these disorders are potentially life threatening and notoriously difficult to treat. There is no definitive consensus as to the etiology of eating disorders. Feminists believe sociological factors such as the oppression of women, and the media’s

portrayals of the ideal woman as thin contribute most significantly to the development of the disorders. The psychological community places the emphasis on issues of control and self esteem. The psychiatric community believes in a biological component to the disorders. Likely, sociological, psychological and biological factors all have a role in eating disorders which contributes to the complexity of the disorders and the inherent difficulty in treating them.

Defined “by the successful pursuit of thinness through dietary restriction and other measures, resulting in body weight below the normal range (usually operationalized as $\leq 85\%$ of expected weight or a body mass index [BMI] $\leq 17.5 \text{ kg/m}^2$)” (Wilson, Grilo & Vitousek, 2007, p. 199), anorexia nervosa strikes both men and women throughout the life span. Though, according to The National Alliance on Mental Illness (NAMI), 90 percent of those affected are adolescent and young women.

Bulimia nervosa, defined by the consumption of an excessive amount of food in a short period of time (bingeing) and the subsequent purging of the food typically through induced vomiting, also mainly affects adolescent and young women. An obsession with controlling body weight characterizes both anorexia and bulimia nervosa.

This study involved nine women in treatment at an eating disorder clinic. The women completed the exercise individually, though in a group setting; the women did not engage with one another during the exercise. Although all of the participants were women, they represented a wide range of ages and time in treatment, and a variety of attitudes and engagement with their eating disorder and treatment process. The exercise was completed during normally scheduled groups at the clinic and was led by the clinician who normally facilitated the groups. After concluding the exercise, the

participants completed a questionnaire with open ended questions about the dialogue writing process and their experience with it.

This study examines the process of dialogue writing and informs potential adjustments in the presentation of the exercise, and its potential to aide patients with eating disorders to externalize their eating disorder which, according to past research, contributes to successful treatment outcomes. Issues of power and control, contradictions inherent in certain thought processes, emotional responses, and changes in attitude emerge from this study. Additionally, the study explores the ability of the dialogue writing process to meet patients where they are at in their relationship with their eating disorder and in their therapeutic process.

CHAPTER II

LITERATURE REVIEW

The literature in this area does not exist for my specific research questions: Are people with anorexia or a related binge eating disorder able to follow the dialogue writing process? What, if anything, do people learn about themselves and their disorder during the dialogue writing process? However, much has been written about narrative therapy and externalizing the problem which informs my research. Cognitive behavioral therapy (CBT), a commonly used treatment modality for eating disorders, is also discussed. Feminist theory also informs some of the treatment for eating disorders as it relates to an external, societal influence over the manifestation of the disorder. A few studies have examined psychodynamic approaches to eating disorders. An adjunct to other therapies, motivational interviewing, or motivational enhancement therapy is discussed. Psychodrama and drama therapy have also been seen as effective treatments for eating disorders and informs some of dialogue writing techniques. Additionally, writing as a therapeutic process with a variety of populations is addressed. Also writing with populations who have been traumatized, which is common amongst people with eating disorders, has been found to be therapeutic. Expressive writing is also specifically addressed in the literature as a powerful intervention for a variety of populations. Finally, the focus of different types of treatment is discussed in terms of what patients find effective and useful in their recovery process.

Narrative Therapy

Narrative therapy, as presented by Michael White and David Epston (1990) in their seminal text *Narrative Means to Therapeutic Ends*, seeks to externalize a person's problem and the narrative that corresponds to it, analyzing it and creating a new narrative where the problem no longer pervades or controls that person. White and Epston describe this process: "The externalization of the problem-saturated story can be initiated by encouraging the externalization of the problem, and then by the mapping of the problem's influence in the person's life and relationships" (White & Epston, 1990, p. 16).

A key factor in the beginning work of narrative therapy, the externalization process, addresses the tendency among clinicians and patients themselves to objectify the person. White and Epston explain that, "The process associated with the externalizing of problems can be considered counter-practices that engage persons in the "de-objectification" of themselves, their bodies, and each other" (White & Epston, 1990, p. 66). Many have theorized that the proliferation of eating disorders emanates from society's objectification of people, and the female body in particular; therefore, the process of "de-objectifying" the body through externalization lends itself well to the treatment of eating disorders. Maisel, Epston and Borden (2004) in their book *Biting the Hand That Starves You* expose the dangers of objectifying the person with an eating disorder by stating that the person "after having first been rendered an object by anorexia, becomes an object again – an object of speculation, theorizing, interpretation and treatment" (p. 80). The basis for dialogue writing comes from this idea of externalizing and objectifying the problem which aides in the eradication of the ever prevalent objectification of the self by the self, society and therapists.

Maisel, Epston and Borden (2004) elaborate on the phenomenon of pathologizing the person when the problem is not externalized: “This view of the “self” as the problem...makes it more likely that people who come under a/b’s (anorexia/ bulimia’s) influence will be viewed by others as having “disordered” minds. This allows a/b to maintain its invisibility, as the problem is attributed to the person, instead of to a/b itself” (p. 77). Furthermore people with eating disorders face a particularly insidious result from the pathologizing attitudes of helping professionals.

Consequently, the person usually comes to view herself as “an anorexic” or “a bulimic”. This all too often prompts the “patient” to try to be a “perfect anorexic” for the doctor or other professional, because a/b fosters in many a desire to please others and live up to their expectations, as well as a desire to be the best. (Maisel, Epston and Borden, 2004, p. 77)

Additionally, in externalizing the problem the person with the eating disorder defers blaming themselves for their disorder as described by Madigan and Goldner (1998): “Hence, anorexia is not viewed as “living inside” the person, nor is it seen as a manifestation of an act of control on the part of the person or a means of “getting attention (Bordo, 1990)” (p. 382).

The externalization of the problem extends to an externalization of the story created around the problem which allows people “to experience a sense of personal agency” (White & Epston, 1990, p. 16). Dialogue writing increases the personal agency that accompanies the externalization of the story by encouraging the person to elaborate on the story through their dialogue with the problem.

Finally, narrative therapy implores the person to develop a new, more positive narrative to replace the problem narrative. White and Epston (1990) state that “when

persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities – new meanings that persons will experience as more helpful, satisfying, and open-ended” (p. 15). The authors expand on the concept of creating a new narrative by suggesting that when a sense of performativity accompanies this process the person examines themselves and their process in a way that enhances the therapeutic process.

...invitations for persons to engage in activities that generate an awareness of a process in which they are simultaneously performers in and audience to their own performance, and a consciousness of one’s production of one’s productions, provides for a context of reflexivity. (p. 18)

The use of playwriting as a technique in the externalization process, like in dialogue writing, invigorates the performative aspect of the activity and, thus, its reflexive nature. White and Epston (1990) comment on how becoming a part of your own performance of the altered narrative can reinforce the story as well as empower the individual. Furthermore, the authors suggest that the inclusion of an audience to the “performance” increases and extends the positive effects of the narrative process. Dialogue writing allows for the possibility of an audience when conducted in a group setting where participants share their dialogues; even when dialogues are not shared within the group, the therapist always acts as an audience for the written dialogue.

Madigan and Goldner in their article, *A Narrative Approach to Anorexia: Discourse, Reflexivity, and Questions* (1998), describe a pilot study using narrative therapy and a control group. Ten women in the narrative group and ten women in the control group attended eight group sessions. The narrative therapy group was more likely to attend the sessions and commit to treatment. A few weeks after the study, the narrative

therapy group reported more hopefulness and less shame. (Madigan & Goldner, 1998). In *Externalizing the Problem of Bulimia: Conversations, Drawing, and Letter Writing in Group Therapy* (1993), Zimmerman and Shepherd organized a group for people with Bulimia which met once per week for eight weeks. In addition to art therapy, the group utilized letter writing “as a way to dialogue with the bulimia influence to further externalize the problem” (Zimmerman & Shepherd, 1993, p. 24). The group consisted of nine undergraduate women who had all received therapy for bulimia prior to the study. The group took place at a University Counseling Center. The first step in the group process was to externalize the problem by having each participant give bulimia a name; similarly, dialogue writing begins with the participants creating a character out of their eating disorder. Additionally, the participants wrote letters to their bulimia, and similar, to my process, the “members utilized the letter to say good-bye to the influence, to demand it leave or to say how it made them feel” (Zimmerman & Shepherd, 1993, p. 28). Group members felt that the experience had a positive influence on their eating disorder and their own self concept.

Weber, Kierynn and McPhie’s study *Narrative Therapy, Eating Disorders and Groups: Enhancing Outcomes in Rural NSW* (2006), worked with seven women for ten weeks between the ages of 20 and 39 years from Wales who self identified as having an eating disorder and depression and used narrative and motivational enhancement therapy; both of these modalities utilize externalization in their process as described by the authors: “For example, this may include conversations that linguistically create a sense of the person being completely separate to the problem, with an identity (intentions, hopes, dreams) separate to the problem” (Weber, Davis & McPhie, 2006, p. 393). The process

also included personification of the eating disorder and an interview with it. In true narrative form the authors also encouraged the use of the term “eating problem” rather than “eating disorder”, the latter which tends to pathologize the person.

The researchers used the Eating Disorders Inventory (EDI) – 3 along with a depression scale to measure the women’s progress. In an evaluative survey, “All women reported changes in daily practices, including less purging, less bingeing, less self-criticism and more active use of certain ideas/strategies, such as embracing risk and appreciating body parts” (Weber, Davis & McPhie, 2006, p. 398). However, this study had its limitations in that it utilized a very small sample, no control group and only examined the results on a short term basis. Furthermore, the study did not focus specifically on externalizing the problem. In addressing its own limitation, though, the authors defend their study stating that, “at the outset, care was taken to state that the women were not expected to make changes while participating in the group; rather, the approach taken was that of exploring ideas and options. This may have had the effect of taking the pressure off, and yet also fits with the (narrative) ethic of co-research” (Weber, Davis & McPhie, 2006, p. 400-401).

In Padula and Rees’ paper, *Motivating Women With Disordered Eating Towards Empowerment and Change Using Narratives of Archetypal Metaphor* (2006), they propose utilizing narrative therapy and motivational interviewing along with archetypal images from myths and fairy tales in the treatment of eating disorders. The authors point to the ever present issue of control in people with eating disorders and how the externalization process can help alleviate this issue by placing “the attention on something outside of the therapist and client relationship (Wood, 2000)” (Padula & Rees,

2006, p. 64). In their proposal, the object outside of the relationship to which attention was turned was the pre-existing archetypal images. In dialogue writing, the object would be the images created by the participants of the eating disorder and its machine. The advantage of using images created by the participants, as in dialogue writing, rather than pre-existing images chosen by the therapist occurs in the ownership of the images as well as the personal agency that comes with their creation.

Narrative Thinking and the Emergence of Postpsychological Therapies (McLeod, 2006) is an informative article on the use of narrative in therapy. In its description of narrative, the use of dialogue writing emerges from the subtext. In an analysis by Schafer the creation of a “storyline” and the guidelines that govern it are said to include “dramatic scenes” (McLeod, 2006, p.203). Schafer continues in his description of the re-telling of the story as necessitating the use of “action language” (2006, p. 203). In dramatic theory, dialogue is necessarily action oriented. The most relevant example in this article of the use of narrative therapy with people who have anorexia includes an examination of Epston and Maisel’s account of a young woman identified as having anorexia where the therapist focused on creating the “voice of perfection” (2006, p. 206). By externalizing anorexia the patient can resist this “voice”. Actually giving a voice to anorexia, or the impetus towards perfectionism pervasive in this disorder, by creating a character who speaks through written dialogue, as in dialogue writing, expands and enhances this theory.

Countering That Which is Called Anorexia, (Lock, Epston, Maisel, 2004) examines the use of externalizing the problem with patients who have anorexia. The article argues that anorexia stifles the voice of its victims and that through narrative

therapy a voice can be given to both the patient and the disorder. It dismisses the medical model which fuses the person with the diagnosis, giving them one voice which inevitably defines the person leaving them to identify more with the disorder than with themselves. The article points to the technique of personifying the problem and the therapeutic effect of conversing with the “voice” of anorexia. Again, this idea that anorexia has a “voice” that exists outside the self and the advantages of dialoguing with that voice presents itself. One of the authors of *Structured Therapeutic Writing Tasks as an Adjunct to Treatment in Eating Disorders* (Schmidt, Bone, Hems, Lessem & Treasure, 2002) which analyzes the phenomenon of experiential avoidance among people with anorexia and a variety of therapeutic writing techniques to aid in overcoming this obstacle, created a writing exercise called “A day in the life of my stomach” where the patient writes a story from the perspective of their stomach. This is a technique used to externalize and objectify the problem and “presents options for dialogue” (Schmidt, Bone, Hems, Lessem & Treasure, 2002, p.299). This type of exercise could easily translate into a written dialogue between the patient and their stomach. Additionally, the article emphasizes the attachment issues that often go along with anorexia, and suggests that “writing from the perspective of self or other may help eating disorder patients to improve their reflective functioning” (2002, p. 308). The authors found that in their experience the majority of patients found it difficult to comply with the tasks; they believe the process or the anticipation of the process may be too distressing for many. I believe a careful and gradual introduction into writing dialogue may help overcome these hesitations.

In her book, *Life Without Ed* (2004), Jenni Schaefer, a survivor of an eating disorder, and her therapist Thom Rutledge write about dialoguing with the eating disorder

as an effective treatment modality. Schaefer writes, “As part of my therapy, I kept a journal. I learned to write the dialogue between Ed (Eating disorder) and me” (Schaefer & Rutledge, 2004, p. xxiii). One of the exercises in the book discusses having a conversation with Ed as a role play where the patient uses two chairs and switches between the chairs taking on the role of the self and then of Ed. Schaefer writes about the helpfulness of this type of exercise. I believe dialogue writing is even more helpful in that it provides tangible evidence of the work which the patient can review afterwards, reinforcing the work done through the dialogue. Role playing can be very helpful as will be discussed in the section on drama therapy and psychodrama, but I believe the actual process of writing the dialogue provides benefits that role playing does not. In addition to the tangible aspect, the process of writing reinforces thought processes and engages different parts of the brain.

Cognitive Behavioral Therapy

In cognitive behavioral therapy (CBT), “a patient, closely assisted by a therapist, investigates the basis in reality for a personal hypotheses concerning the world” (Freeman, 1995, p. 309-310). Although CBT has not been found as successful for Anorexia Nervosa, for Bulimia Nervosa, “Cognitive-behavior therapy is considered to be the treatment of choice due to its impressive outcomes in controlled research (e.g., Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Peterson & Mitchell, 1999)” (Openshaw, Waller, Sperlinger, 2004, p. 364). Despite its popularity, though, according to Openshaw, Waller and Sperlinger, “50–60% of clients remain symptomatic after treatment (e.g., Agras et al., 2000; Fairburn et al., 1995; Garner et al., 1993; Wilson & Fairburn, 1993), and this percentage may increase at follow up (Vaz, 1998)” (2004, p. 364).

Openshaw, Waller and Sperlinger's study *Group Cognitive-Behavioral Therapy for Bulimia Nervosa: Statistical Versus Clinical Significance of Changes in Symptoms Across Treatment* (2004), analyzed a CBT treatment in a group format which included interpersonal aspects such as relationship issues and the communication of emotions. The researchers felt that a pure CBT approach that did not address the issues of relationships and communication of feelings was too narrow. "A simple focus on the reduction of bulimic behaviors fails to allow for the need to modify a wider range of attitudes and affects" (Openshaw, Waller, Sperlinger, 2004, p. 365).

Twenty-nine participants, 1 man and 28 women, who were all diagnosed with Bulimia Nervosa according to the DSM-V were given Stirling Eating Disorder Scales, the Beck Depression Inventory, and the Beck Anxiety Inventory during the assessment period, before treatment, after treatment and 6 months post treatment. The study addressed the following:

... introduction, dealing with the diet/binge cycle, nutrition and weight, stress management, dietary energy and associated issues: managing myths & reality, body image, cognitive therapy, challenging negative thinking workshop, exploring relationships, communication and expressing feelings, assertiveness, maintenance and relapse prevention, termination. (Openshaw, Waller, Sperlinger, 2004, p. 366-67)

In addition, the participants completed "food and feelings" diaries which connected "psychological factors and eating-disordered thinking and behaviors" (Openshaw, Waller, Sperlinger, 2004, p. 366). At the follow-up period 45% of participants had improved according to the positive change in their SEDS totals. Although, a 45% success rate among participants seems to be within the expected range

for treating eating disorders, it remains a dismal prospect for those who struggle with an eating disorder.

In *Cognitive –Behavior Therapy With Eating Disorders: The Role of Medication in Treatment* (Bowers & Anderson, 2004), the authors discuss the use of CBT as well as medication therapy for bulimia nervosa, anorexia nervosa and binge eating disorder. The article cites several studies that suggest that CBT can be effective for anorexia nervosa as well as bulimia nervosa. “Although detailed treatment manuals have yet to be published providing step-by-step procedures for treating anorexia nervosa, several authors have written about specific CBT approaches to the treatment of this disorder (Garner, Vitousek, & Pike, 1997; Wilson, Fairburn, & Agras, 1997)” (Bowers & Anderson, 2004, 20). The results of their analyses of studies using CBT for Bulimia Nervosa showed CBT alone, or a combination of CBT and medication was more effective than medication alone (Bowers & Anderson, 2004). The authors also point to the lack of research studies in the treatment of Anorexia Nervosa, “However, in the treatment of anorexia nervosa, CBT and nutritional rehabilitation play primary roles while medications are secondary, especially during inpatient treatment (Bowers & Ansher, 2000; Mitchell et al., 2001; Steinglass & Walsh, 2004; Wilson et al., 2000)” (Bowers & Anderson, 2004, 21).

Corstorphine’s article, *Cognitive-Emotional-Behavioral Therapy for the Eating Disorders: Working With Beliefs About Emotions* (2006), discusses the use of Cognitive-Emotional-Behavioral Therapy (CEBT) for eating disorders which “is aimed at enabling patients with eating disorders to understand the experience and expression of emotions, so that they can identify and challenge their beliefs and attend and respond to their emotions adaptively” (2006, p. 451) The CEBT process begins with psychoeducation

about emotions and their expression. The patient keeps a diary of their emotions, and their functions which “will help the patient to develop the confidence that is necessary to begin to challenge her beliefs by experimenting with different ways of responding to them” (Corstorphine, 2006, p. 456). In a similar way, dialogue writing allows the patient to experiment with different ways of responding to the beliefs instilled in her by the eating disorder. Corstorphine also discusses how CEBT enables the patient to remove themselves from their emotions, much like the externalization process in dialogue writing. Corstorphine even encourages naming the emotions, stating, “there is some evidence that people who ‘give emotion a name’ are better able to control the emotion” (2006, p. 456). Similarly, naming one’s eating disorder, as is prescribed in dialogue writing, gives the patient more control over the disorder and the emotions it elicits. The final step in the CEBT process utilizes CBT to identify and restructure emotions and thoughts about emotions (Corstorphine, 2006).

Mountford and Waller (2006) argue in favor of CBT and against externalization in the treatment of eating disorders.

...there is an inherent risk in encouraging patients to externalize elements of their anorexia, since these are likely to be the ego-dystonic elements, resulting in their being less willing to engage in treatment. If the patient is encouraged to reduce her responsibility for the cause and maintenance of the disorder, then she is also able to disown responsibility for change. Such externalizing also allows the patient and others to discount key elements of the disorder, such as negative emotional states. Vitousek points out how the tendency for patients, clinicians, and family to discuss externalized elements of the anorexia means that there is less likelihood that the individual patient will be able to work towards resolving confused feelings, motivations, and behaviors. (Mountford & Waller, 2006, p. 534).

Proponents of externalization in the treatment of eating disorders would argue that displacing blame for eating disorder behaviors away from the self does not necessarily cause the person to “disown responsibility for change”. In the dialogue writing process, negative emotional states, confused feelings, motivation and behaviors are not discounted, but addressed in the context of their interaction with the eating disorder. In the externalization process the patient can be viewed as a victim of the disorder in the same way a person can be a victim of domestic violence. Blaming one’s self for the abuse will perpetuate the cycle of victimization; however the victim must take responsibility for getting help to stand up to the abuser. Similarly with eating disorders, placing blame on the self will serve to further decrease what is often a shrunken self esteem which only enhances the eating disorder’s grasp on the person. In contrast, “Externalizing conversations reverse the vocabulary of self-blame, self-reproach, self-hatred and guilt that a/b employs to represent people” (Maisel, Epston & Borden, 2004, p. 81). Much like victims of domestic violence, the eating disorder patient takes responsibility for getting the help to stand up to their abuser: the eating disorder. Additionally, blaming the self for the eating disorder will certainly alienate many patients. In a Newsweek article about the popularity of pro-anorexia websites (sites which provide “support” for people with anorexia to continue what they consider their chosen lifestyle) one woman describes the appeal of the sites as a place where “I could talk about the illness without people trying to fix me or tell me that what I’m doing is horrible, disgusting and maladaptive” (Peng, 2008, p. 1). It is this blaming, pathologizing attitude which turns many people with eating disorders away from seeking help.

In Mountford and Waller's study, *Using Imagery in Cognitive-Behavioral Treatment for Eating Disorders: Tackling the Restrictive Mode* (2006), the authors discuss the use of imagery alongside CBT in the treatment of eating disorders, but in a very different modality than dialogue writing; "we discuss the image as explicitly representing part of the patient's own self, rather than as being a discrete entity" (Mountford & Waller, 2006, p. 534). The patients were encouraged to see different "schema modes" within themselves as different aspects of their personality with the eating disorder as one part of themselves that attempts to control other aspects of themselves. Later in the treatment, the patients "focused on learning the "anorexia's" common phrases (e.g., "You do not really need help—you are fine with me"), actions (e.g., comments on her legs) and disguises" (Mountford & Waller, 2006, p. 540). This aspect of the treatment appears similar to the dialogue writing process, but the eating disorder in this study is an integral part of the self; whereas, with dialogue writing, the eating disorder is seen as an external entity.

The authors identified the use of this technique with 10 patients where the outcome was positive in 9 cases (Mountford & Waller, 2006). Despite the positive outcomes, the sample size is too small to draw a significant conclusion about the effectiveness of this intervention; however, as was stated above, the dangers of addressing the eating disorder as an internal flaw encourages the person with the eating disorder to blame themselves which can lead to lower self esteem, a rejection of therapy and a more virulent eating disorder.

Feminism

According to feminist theory, eating disorders find much of their roots in a patriarchal society which objectifies the female body, and disempowers women. Because eating disorders affect women far more often than men, feminist theory is often applied to the issue. According to Padulo and Rees,

It is more common for men to turn their aggression out on the world, while women tend to turn their aggression in on themselves (Rust, 2000). In a sense, this makes the patriarchal system very efficient since women naturally turn their aggression inward, maintaining their own strictly confined order and alleviating any threat to the structure of the system. (2006, p. 65-66)

Eating disorders can be seen from this perspective as aggression turned inwards which benefits the patriarchal society. Foucault, who is also embraced by feminist theorist such as Judith Butler, provides the philosophical basis for narrative therapy and is discussed at length by White and Epston: “According to Foucault, in recent history, western society has increasingly relied on the practices of the objectification of persons and their bodies to improve and extend social control” (1990, p. 66). From a feminist perspective, objectification of the female body in order to maintain control over women has also increased. Externalizing the problem works well alongside feminist theories of eating disorders in that “practices associated with the externalization of problems may be considered counter-practices to cultural practices that are objectifying of persons and of their bodies” (White and Epston, 1990, p. 75). Dialogue writing, with its basis in externalization, also provides an opportunity for people with eating disorders to address the extent of their own objectification by examining the voice of the eating disorder which may be influenced by the voice of a patriarchal society. According to Foucault,

“He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes himself in the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjugation (1979, p. 202)” (White & Epston, 1990, 71). Padula and Rees agree with Foucault in that women become their own oppressors in the form of an eating disorder. “In the life of a woman with disordered eating there is a battle of opposites with the body as the killing field. She participates in the society she despises by fashioning herself into what is most acceptable and deemed beautiful” (Padula & Rees, 2006, p. 66).

Malson, Clarke and Finn conducted interviews with 38 females and 1 male between the ages of 14 and 45, all of whom had at least one hospitalization for anorexia or bulimia. Half of the participants were from an adolescent eating disorders ward in the UK and half were from a large hospital in Australia. The researchers found typical treatments for eating disorders often reinscribed the pathology of the eating disorders. In particular, the authors suggest that living in a society preoccupied with weight loss, particularly for women, and the practice of weighing the patient with the eating disorder only perpetuated the obsession with weight that accompanies eating disorders.

...participants in our research talked about how an ‘obsession’ with body weight and weight management was central to both ‘anorexic’ and treatment practices (Malson, in press). Monitoring of patients’ body weights and eating was constituted not only as inevitable or necessary but also as anorexia-like and potentially anorexogenic or anorexia sustaining. (Malson, Clarke & Finn, 2008, p. 419).

Dialogue writing moves away from the preoccupation with weight management which, according to feminist theorists, can perpetuate the objectification inherent in the eating disorder and the obsession with weight and body image found in society.

Psychodynamic Treatment

Murphy, Russell and Waller's study *Integrated Psychodynamic Therapy for Bulimia Nervosa and Binge Eating Disorder: Theory, Practice and Preliminary Findings* (2005), discusses the advantages of a more interpersonal approach such as psychodynamic therapy to bulimia nervosa as opposed to the commonly used CBT.

Although many studies advocate the use of cognitive-behavioural therapy (CBT) for patients with bulimia nervosa and binge eating disorder (Fairburn & Harrison, 2003; National Institute for Clinical Excellence, 2004), a substantial number of such cases do not recover with CBT alone (Wilson, 1999). It has been suggested (e.g. Fairburn, Cooper, & Shafran, 2003; Waller & Kennerley, 2003) that the CBT model needs to be enhanced. One area for such development is the interpersonal domain, as reflected in positive outcomes when interpersonal psychotherapy (IPT) is used (e.g. Fairburn & Harrison, 2003). (Murphy, Russell & Waller, 2005, p. 384)

This study consisted of 21 female patients who met the DSM-IV criteria for bulimia nervosa or binge eating disorder. The mean age was 33.7 years and the bingeing mean was 7 per week. Patients were chosen who had some comprehension of the psychological or emotional components of eating disorders, an interest in the self, an understanding of their part in effecting change, an ability to develop a relationship with a therapist, an interest in changing, likelihood of regular attendance and a system of support. After an initial assessment the patients attended weekly therapy (a mean of 26.9 sessions per patient) and then follow-ups. The patients were expected to keep a weekly diary of food behaviors and emotional states, and to accept a prescribed eating plan and

weekly weighing. “The majority of the patients who completed treatment became free of the behavioral symptoms, and hence left the diagnosable category” (Murphy, Russell & Waller, 2005, p. 389). The authors suggest that these findings indicate that a time limited psychodynamic treatment approach coupled with behavioral elements can be effective in treating bulimia nervosa. While this study shows promising results, the behavioral methods used (e.g. regular weighing of patients and diet monitoring) have been reported by patients with eating disorders as perpetuating the eating disorder mentality as described in the Malson, Clarke and Finn study (2008). Additionally, the authors themselves admit “psychodynamic therapy is available only to a limited number of patients, because of the time necessary for working through the transference neurosis” (Murphy, Russell & Waller, 2005, p. 384).

A Psychodynamic approach to eating disorders also tends to emphasize the problem as inherent in the person. Even after discussing the “voice” of anorexia as described by people with eating disorders as an external entity, Dare and Crowther (1995) state that when treating patients with eating disorders in a psychoanalytically informed psychotherapy, it is the therapeutic task “to help the patient recognize that both tyrant and victim are equally her own” (Dare and Crowther, 1995, p. 302). It has already been stated that this type of approach tends to make many patients resistant to therapy and may even encourage participation in pro-anorexia “support groups”.

Motivational Interviewing/ Motivational Enhancement Therapy

Motivational interviewing, or motivational enhancement therapy as it is also called, has also been mentioned in the literature (Padula & Rees, 2006) as an effective co-therapy with other externalizing approaches. “The theory behind motivational

interviewing is that lasting change has to come from the decision of the woman, not from the therapist or other individuals in the woman's life" (Padula & Rees, 2006, p. 70). This approach fits well with the theory of externalizing the problem; while other theories emphasize the problem as within the woman the resulting tendency is often for the therapist to convince the patient of their pathology; whereas, in order to externalize the problem, the person must first recognize the existence of the problem, and this inherency forgoes the need to "convince" the person to change.

In Weber, Davis and McPhie's (2006) study, discussed earlier in this paper, all of the women in the study asked for a continuation of the group. The authors suggest that "Consistent with motivational enhancement therapy, the request could also be read as an increase in participants' level of motivation to sustain the changes they had made and possibly to explore making further changes" (Weber, Davis & McPhie, 2006, p. 402). Motivational interviewing/ motivational enhancement therapy may be a good adjunct to dialogue writing.

Psychodrama and Drama Therapy

Psychodrama and drama therapy both utilize role playing as the main modality of therapeutic treatment. Externalization of the problem becomes a natural part of this process as participants are often asked to "play" different aspects of themselves and interact with others in the group who "play" other parts of that person. One of the most frequently used exercises in psychodrama, role reversal, has the "protagonist", or patient who is the focus of a particular role play, reverse roles with another member of the group who often plays a specific part of the protagonist's self such as an emotion. Role reversal

is used “when trying to explore the protagonist’s relationship to herself” and well as “help the protagonist understand this aspect of herself better” (Jay, 1995, p. 180).

Rubin, a drama therapist discusses exercises she uses with women who have eating disorders in her article, *Women, Food and Feelings: Drama Therapy With Women Who Have Eating Disorders* (2008). One exercise has the women write a letter to their eating disorder discussing their relationship with it. Next the women write a letter from the eating disorder to themselves telling the women why it is needed (the eating disorder). Finally, the women write a third letter from themselves to the eating disorder explaining how things are changing and exploring new ways of relating to the eating disorder. Dialogue writing clearly uses the same tactics; however, in dialogue writing, the women are given more of a specific structure to follow which may allow for more intensive exploration of the issues and a guidance that makes the process easier and less intimidating.

The Body Dialogue: An Action Intervention to Build Body Empathy (Ciotola, 2006) describes a role playing technique that invites participants to have a conversation with their body in an effort to appreciate their bodies. This technique is similar to dialogue writing except that it is done as a role play and the emphasis is on creating an appreciation for the body rather than externalizing a problem associated with the body.

Therapeutic Aspects of Writing

According to Padula and Rees, “When a link is provided between the mind and body through the writing of stories, the woman is given a forum for symbolic thought and communication to develop (Wood, 2000)” (Padula & Rees, 2006, p. 68-69). The overall therapeutic aspects of writing include the ability to project difficult topics or emotions

onto fictionalized characters as is discussed in *Integrating Writing into Psychotherapy Practice: A Matrix of Change Processes and Structural Dimensions* (Kerner & Fitzpatrick, 2007).. The article analyzes different techniques for therapeutic writing including storytelling where patients “approach their distress by projecting experiences that are too painful to talk about on to fictional characters” (Kerner & Fitzpatrick, 2007, p. 338). Dialogue writing is a form of storytelling where fictional characters can be created who represent the experiences of the patient. *Scriptotherapy: Therapeutic Writing as a Counseling Adjunct* (Riordan, 1996) is a review of the literature on writing in the therapeutic process. The article describes the use of fictional writing with a rape victim who was able to “master the trauma by altering the fictional circumstances” (Riordan, 1996, p. 3). It goes on to explain that through the creation of a fictional character separate from her, the woman was able to relive the trauma. Dialogue writing lends itself well to the creation of a character who can revisit painful experiences from a safe distance within the world of the “play”.

Writing with Trauma Survivors

According to Schmidt, Bone, Hems, Lessem and Treasure in *Structured Therapeutic Writing Tasks as an Adjunct to Treatment in Eating Disorders* (2002), “Nearly three-quarters of eating disorder patients report a history of trauma” (2002, p.300). *A Comparison of Written Emotional Expression and Planning with Respect to Bulimic Symptoms and Associated Psychopathology* (Frayne & Wade, 2006) investigated writing about trauma and its ability to decrease disordered eating. One hundred two female first year students volunteered for the study. There is no data available on the race of the participants. An emotive writing group focused on traumatic events compared to a

non-emotive control group who wrote about future planning. Measures included: Body Mass Index, Profile of Mood States, Coping Operations Preference Enquiry, Eating Disorder Examination Questionnaire, The Interoceptive Awareness sub-scale of the Eating Disorders Inventory (EDI), the Ineffectiveness sub-scale of the EDI and the Externalised Self Perception sub-scale of the Silencing the Self Scale. The unexpected outcome showed a greater improvement in the control group. However, the use of a non-eating disordered population of students limited this study's ability to assess the advantages of writing while suffering from an eating disorder. I believe that this type of study, replicated with an eating disordered population would obtain different outcomes. Although not examining eating disorders specifically, *Confronting a Traumatic Event: Toward an Understanding of Inhibition and Disease* (Pennebaker & Beall, 1986) found a significant decrease in health problems among those who wrote about both the trauma and the emotions related to it. This study took 46 undergraduates, 34 women and 12 men, and randomly assigned them to one of four types of writing exercises in an exploration of the therapeutic possibilities of writing about a traumatic event. No breakdown of race or ethnicity was reported. The groups included a control group who wrote about trivial topics, two groups writing about trauma and one group combining trivial topics and traumatic events. For four days after each writing exercise, the subjects completed a short questionnaire assessing their physical symptoms and moods, and had their pulse and blood pressure taken. Four months after the exercises the participants were mailed the same health questionnaire filled out at the beginning of the experiment. The study points to "the importance of emphasizing the emotions that coincide with the objective (or at least perceived) trauma" (Pennebaker & Beall, 1986, p.280). Given the high rate of

trauma amongst patients with anorexia these findings illuminate the need for emotional content within the writing experience. Therefore, writing dialogue may need to be supplemented with monologues, which tend to allow for more exploration of personal emotions.

Expressive Writing

Expressive writing was also found to benefit other populations with mental health issues. *Benefits of Expressive Writing in Lowering Rumination and Depressive Symptoms*, (Gortner, Rude & Pennebaker), 2006 looked at 90 undergraduate students with self reported symptoms of depression in the past, but who were non-symptomatic at the time of the study. The study included a majority of Anglo participants with a smaller group of Latino/ Hispanic and Asian participants. The study was interested in whether or not expressive writing, compared to control writing lowered depressive symptoms for students with a history of depression. The group was randomly divided into an expressive writing group and a non-expressive writing group. The Beck Depression Inventory, the Inventory to Diagnose Depression, the Ruminative Response Scale and the Emotion Regulation Questionnaire as well as a follow up questionnaire on Participant's Subjective Experience was utilized. The study found an overall decrease in depressive symptoms among the expressive writing group. This study confirms the efficacy of expressive writing in a therapeutic context.

Treatment Focus

In *The Individual Within a condition; A Qualitative Study of Young People's Reflections on Being Treated for Anorexia Nervosa* (Tierney, 2008), ten Caucasian teenagers between the ages of 11 and 18 years of age were interviewed about their views

of treatment for their disorder. Many themes emerged from this study, but the most relevant themes to my study pointed to the need for an emphasis on the mental progress of the patient and the psychosocial aspects of their selves. The teens consistently regarded the over emphasis on the physical aspects of their disease as disregarding the importance of the mental aspects of the disease. This confirms the belief that tackling the psychological issues involved with anorexia nervosa will increase positive treatment outcomes. Dialogue writing gives the patient the opportunity to explore their psyche in a unique and therapeutic way.

Emotional Responses to Food in Adults With an Eating Disorder: A Qualitative Exploration (McNamara, Chur-Hansen, Hay, 2008) interviewed 10 adult women with anorexia nervosa after showing them pictures of food. The study explored the emotional responses to the pictures. The main theme to emerge from this study was control. The women all described issues of control in regards to food. Dialogue writing can address these issues of control by having patients have a discussion between themselves and food, or themselves and the problem of control as personified and externalized.

Narrative therapy and externalizing the problem emerge as new and hopeful treatments for eating disorders. Dialogue writing capitalizes on the most effective aspects of this treatment form, allowing patients to externalize the eating disorder, become familiar with the story that has developed around it, and change that story in a very empowering way. CBT, although widely used for eating disorders, still maintains fairly dismal outcomes statistically, and may encourage the counterproductive act of pathologizing the patient which dialogue writing seeks to avoid. Dialogue writing does not conflict with feminist theories about eating disorders as it would embrace the idea

that the eating disorder has an external source, possibly the patriarchal society in which we live. Psychodynamic psychotherapy, used less often with this population, may perpetuate the internalization of the problem resulting in self blame and treatment resistance. Motivational interviewing or motivational enhancement therapy prove effective in treating eating disorders in some cases as an adjunct to other therapies, including those that externalize the problem. Psychodrama or drama therapy do not always emphasize the external nature of the problem, as in dialogue writing, but do inform some of the aspects of dialogue writing, such as creating conversations with different aspects of the self. Additionally, therapeutic writing techniques that utilize the expression of emotion have shown to be helpful with trauma patients; there is a high prevalence of trauma amongst people with anorexia and bulimia. Monologue writing as an adjunct to dialogue writing would work particularly well with this population of trauma victims who have anorexia or bulimia. Additionally, effective treatments for anorexia nervosa include an emphasis on the psychological processes, issues of control and dialogues with the body.

CHAPTER III
METHODOLOGY

Study Design and Sampling

My research questions are: Are people with anorexia or a related binge eating disorder able to follow the dialogue writing process? What, if anything, do people learn about themselves and their disorder during the dialogue writing process? This qualitative study utilized a flexible method of open ended questions in order to gather narrative data. Because this type of intervention has not been researched, an initial study investigating its feasibility must occur. For this study, my interest focused on improving the technique and not focusing on therapeutic outcome. Participants were asked to comment on the process more than the effect the intervention had on their treatment.

Because the intervention has not been tested, discovering if people were able to follow the process emerged as the most useful approach to this project. I concluded that if the intervention were found to be user friendly, then further research may be done as to its efficacy in the treatment of eating disorders.

Data Collection

The design of this study was approved by the Human Subjects Review Board of The Smith College School for Social Work (see Appendix A). Informed consent letters were given to all potential participants (see Appendix B). I met with a clinician from the eating disorder clinic who facilitated groups at the clinic and who had been chosen by the Director of the program as the facilitator of the intervention. I reviewed the exercise with

her, and discussed the presentation of the material. I also reviewed with her the guidelines for handling the participants, the importance of voluntary participation, and of informed consent and confidentiality. The clinician also signed a confidentiality pledge (see Appendix C).

Meeting at their regular meeting room at the clinic, the clinician chosen to facilitate the exercise presented the informed consent to the groups, making it clear that while the exercise was a part of their group participation, filling out the questionnaire was not. The clinician led the patients through the dialogue writing process in a group setting; however, each participant worked independently on their own dialogue. After the exercise was completed, those who agreed signed the informed consent and were given a copy of the questionnaire which asked them to respond to the exercise with open ended questions ranging from inquiries regarding the participant's ability to follow the dialogue writing process to emotional responses to the exercise. The signed informed consents were then given to me to sign and then returned to the participants by the clinician. I had no contact with the participants.

Sample Characteristics

The 9 participants were patients at an eating disorder clinic in a major city in the United States. The patients range in age from 18-32 with a mean age of 24. The duration of treatment ranged from 7 days to 6 years with the mean duration being 15 months. As part of the program at the clinic, participants are seen in individual therapy 2 times per week and by a psychiatrist 1-2 times per week. Patients also participate in up to 8 groups per week.

The participants came from two different groups. The first group was an Evening Intensive Outpatient Group that met for eight weeks of psycho education. Three group members participated in the study. The second group was an Authentic Self group which explored family history and personal experiences, and was part of the Partial Hospitalization Program. Six of these group members participated in the study. Both of the groups were 90 minutes in length.

The clinic provided a letter stating that their interest in utilizing the intervention was independent of my research project and that they would be using it with their groups regardless of my research pursuits. (See Appendix D). Therefore, the intervention itself became a part of the regular curriculum at the clinic and was, therefore a prerequisite for group participation; however, filling out the questionnaire following the intervention was entirely voluntary and had no bearing on their participation in the program or the group.

Data Analysis

Questionnaires were reviewed for content and answers were coded for themes specific to the participants' experience with the intervention. Due to the small sample size, universalizing generalizations cannot be made from these findings. Rather the data will provide information for the further improvement of the intervention which may lead to studies exploring its' efficacy as a treatment modality for eating disorders.

CHAPTER IV

FINDINGS

The presentation of the findings will consist of a review of the written responses to the questionnaire. The following themes emerged from the data, were coded and will be explored in this section: the process of dialogue writing and the participant's experience with the process, the extent to which participants were able to externalize their eating disorder, power and control issues, contradictions found within the participant's responses, participant's attitude changes towards their eating disorder, characters created by participants described as abusive men and the extent to which the intervention met participants where they were at. Additionally, statistical information will be provided regarding the outlined themes and details concerning participant's demographics.

Process

All of the questions were open ended and several asked participants to respond in their own words about their experience with the process of dialogue writing. In response to "Please describe how easy or difficult it was to follow the instructions during the exercise" 78% described the exercise as easy. Treatment time within this group ranged from 7 weeks to 6 years. Within that group, two women reported the exercise as simultaneously easy and difficult; one participant, in treatment for 12 weeks, described the instructions as easy, but the exercise as "difficult" and another woman found the instructions "Easy but difficult to understand". This participant's treatment began 7 days prior to participation; this is the shortest duration of treatment of all of the participants.

This participant's answer also contains the comment, (I) "Don't understand myself and Ed (eating disorder)". One other participant, who found the exercise "difficult", and whose total duration in treatment was the second shortest (3 weeks), also commented that she is unfamiliar with herself. All but one participant whose total treatment time consisted of 12 weeks or less described the exercise as less than easy. Those in treatment four years or more described the exercise as "very" and "really" easy. One participant who described herself as "not creative", rated the ease or difficulty of the exercise as "moderate". Two of the participants who found the exercise "very easy" and "easy" also reported loving to write and liking "the idea of creating a script".

When asked "What would have made the instructions easier to understand?" 56% of participants suggested the exercise be less "wordy". Two participants described the questions as "confusing", and two others suggested a visual presentation of the instructions.

Responding to "Please describe how easy or difficult it was to understand the explanation of how to create a character who is representing your eating disorder", 67% described it as easy. Of those 67%, two described a distinct understanding of their eating disorder as a character. One participant, in treatment for 10 months, commented that "my eating disorder is always a character to me", and the other, in treatment for 6 years, responded "my eating disorder is a character I have created to cope." A third, in treatment for 3 weeks, felt that the ease in creating the character arose from having "been close to it for 12 years." Another participant, in treatment for 7 weeks, reported that "a character immediately came to mind". The "voice" of the eating disorder also resonated with three of the participants; one, in treatment for 4.5 weeks, reflected, "its' had a voice for a long

time.” Two others, one in treatment for 6 years and the other for 10 months, reported having the conversation with their eating disorder in their heads every day. One participant, who has been in treatment for 4 years, informed me that she has participated in a similar exercise on a previous occasion. Another, whose total treatment time consisted of 4.5 weeks, reported the ease of creating the character came from already processing it; although she does not elaborate on whether she has processed her eating disorder as a character in her treatment, or in her own personal understanding of the disorder.

Externalizing

The ability to externalize the eating disorder and the narrative around it represents a crucial aspect of the dialogue writing process. Through the creation of a character external to the person, the participant interacts with the character, confronting it and ultimately saying goodbye to the character which represents their eating disorder. The degree to which participants were able to externalize their eating disorder varied. Among the five participants whose total treatment time amounted to three months or less, two reported an ability to externalize their eating disorder and created a character separate from themselves. Three participants reported that they did not fully externalize their eating disorder during the exercise. While one, whose total treatment time was 12 weeks, said she learned of the separateness of her eating disorder, she qualified her statement with “but not so separate that it’s that apart from me!” This same participant responded to the statement “describe how easy or difficult it was to understand the explanation of how to create a character who is representing your eating disorder” by claiming she did not see her eating disorder as a character and expressing, “it is not some monster, it’s my

monster”. In response to “Tell me how it felt to give a voice to this character“ she said, “I didn’t give my character a voice but just a feeling that sits in my throat leaving it raw”. Another participant, with 9.5 weeks of total treatment time, responded to my request to describe the ease or difficulty in understanding the explanation of how to create a character with the response, “I see my eating disorder as a part of me, not as a separate character”. In describing her character she wrote, “it was a part of myself”. When asked about her experience giving the character a voice she claimed, “It makes me sad that it was my voice that I gave her”. The third participant, whose total treatment time was 7 days, wrote that she did not create a character, but used herself. However, in response to “Tell me how it felt to give a voice to this character”, she comments, “I am more aware of my Eating Disorder and how twisted you can get with yourself and your Eating disorder”.

The remaining 6 participants reported an ability to externalize their eating disorder and create a character that represented it. In response to the request “Tell me how it felt to give a voice to this character” the woman in treatment for 7 weeks said it “Made it feel separate. Made me feel like I can de-attach from it.” Another, in treatment for 4.5 weeks felt that “It was easy because it’s had a voice for a long time”. The participant in treatment for 10 months explained that “It felt real, like I was not living only in my head, and that I could actually talk back”. The woman in treatment for the longest duration, 6 years, said it was “Interesting how he has always had a voice, I just never focused on it and wrote it down”.

Power and Control

The theme of power and control also emerged from many of the responses. Seven of the participants mentioned power or control in regards to their relationship with their eating disorder. The participant with the longest treatment time of 6 years gave the most affirmative response to the question “What did you learn about yourself during this exercise?”, stating, “In my life, I control the weather”, referring back to her description of her eating disorder as a “storm”. In contrast, the participant with the shortest duration in treatment, 7 days, expressed the controlling nature of her eating disorder and the power it wielded over her in several responses. In response to the question “What did you learn about your relationship with your eating disorder during this exercise”, she writes, “ED has Control. “Power””. In her report of the emotions experienced during the exercise she says, “I was kind of angry because I’ve let ED control me and my thoughts.” It must be noted that this participant did not create an external character, but used herself as the character. Yet another participant, whose duration in treatment totaled 7 weeks, in response to the question, “What did you learn about your eating disorder during this exercise?” claims, “(It) Doesn’t have as much power” and in response to what she learned about herself during the exercise, she writes, “I have more power than the eating disorder and I’ve taken a lot of power back from ED”.

Contradictions

Many of the participants’ responses were contradictory and varied from one question to the next in terms of their experience with power and control and their eating disorder. One participant, in treatment for 9.5 weeks, who did not externalize her eating disorder but used her own voice instead, stated, “I let my power go” in one response, and

then “I gave it a lot more credit than it deserved” in another response. Another participant, in treatment for 4 years, responded to the question regarding what she learned about her eating disorder with “That the eating disorder is powerful. The “voice” of the eating disorder has a lot of power behind it”. However, in response to what she learned about herself during the exercise she wrote, “That I need to take the power back from the eating disorder”. Yet another participant, in treatment for 3 weeks, described her character as having “all of the control” and “powerful”, but in response to how it felt to give a voice to the character she also wrote “powerful”, and then when asked what she learned about herself during the exercise she said, “I learned that I am strong enough and determined to say goodbye for good”. Two participants provide conflicting information within a single question; one, in treatment for 10 months, wrote, “That I can tell my ed (eating disorder) no and to leave but he has more power then I admit he truly does” when asked what she learned about herself during the exercise. The other participant, in treatment for 4.5 weeks, claimed in response to the question “What did you learn about your relationship with your eating disorder during this exercise?”, “I’m getting ready to start letting go of it. Not fully though. It’s still very important to me”.

Three participants described a contradictory relationship with their eating disorder. In response to “What did you learn about your relationship with your eating disorder during this exercise”, one participant, in treatment for 9.5 weeks, wrote, “It was the most toxic relationship I have ever been in, but it has allowed me to have the healthiest relationship with myself!” Another respondent, in treatment for 10 months, admitted the relationship is “abusive” but in the same sentence claimed, “I feel he truly loves me and makes me better”. This same participant expressed a mixed response to

aspects of the exercise suggesting that in giving a voice to the character she was able to “talk back”, but at the same time she expressed vulnerability and anxiety that the eating disorder will be stronger. The third participant, in treatment for 3 weeks said, “It’s a love hate relationship”.

Emotional Response

Additionally, a mixture of emotional responses appeared throughout the questionnaires. In response to the request, “Describe any positive or negative emotions you experienced during this exercise”, 56% of respondents presented both positive and negative emotions. One participant, in treatment for 4.5 weeks wrote, “That made me feel: conflicted, angry, ashamed, frustrated, lesser, small, cliché, disappointment, faulty, distant, alone, guilty”, and then centered below all of these responses she wrote, “empowered”. Another respondent, in treatment for 10 months, described her anger towards her eating disorder, but continued with an expression of sympathy for the eating disorder which she feels the need to keep safe; however, she does conclude her statement with “I know I can’t”. The participant in treatment for 7 days expressed anger for having allowed her eating disorder to control her and her thoughts. She also expressed a positive response in that she felt she was “Learning to write freely to ED and tell him how I feel.” The participant in treatment for 3 weeks underlined “Wonder why I can’t live a normal life...confusion...hope.” She also wrote, “There is green grass on the other side”. Three participants felt primarily positive emotions during the exercise, two inserted one negative feeling; the first, in treatment for 7 weeks, felt “sadness” in addition to “freedom, joy, love and kindness”, the other, in treatment for 9.5 weeks, expressed “anger” in addition to “relief, happiness and confidence”. The third, in treatment for 6

years wrote, “Positive, I can change the weather”, referring back to her description of her eating disorder as a “storm”. One woman, in treatment for 12 weeks, only expressed negative emotions in response to the exercise saying, “I didn’t like this exercise. It was very difficult for me”. The woman in treatment for 4 years expressed some ambivalence in her response writing, “Didn’t really feel much emotions. Kind of felt mad.” This woman had also reported having done a similar exercise in the past.

Attitude

Eight out of nine participants reported a significant change in their attitude or approach towards their eating disorder during the course of the exercise. One respondent, in treatment for 7 weeks said, “I see it (eating disorder) in a different light/ doesn’t have as much power”. This same participant claimed that what she learned about herself during the exercise included having “more power than the eating disorder and I’ve taken a lot of power back from ED”. Another participant, in treatment for 9.5 weeks, exclaimed “How ready I was to say goodbye!!!” in regards to learning about herself during the exercise. The participant with the shortest duration of treatment, 7 days, included the statement, “Don’t understand myself and Ed”, initially, however, later she commented twice, “I am more aware of my Eating Disorder”. Another participant, in treatment for 3 weeks, whose initial comments included unfamiliarity with herself, announced she learned that she is “strong enough and determined to say Goodbye for good”. In response to the question “What did you learn about your relationship with your eating disorder during this exercise?” one woman, in treatment for 4.5 weeks, claims, “I’m getting ready to start letting go of it”.

Characters as Abusive Men

The idea of the eating disorder characterized as an abusive, yet attractive man arose in two of the participants' descriptions of their character. One woman, in treatment for 10 months, states that her character was

...a controlling boyfriend, he didn't approve of anything I did or he always put me down when I would do something. He is an attractive person, smart. His name was Matthew. When you see him he is desirable. He comforts me when I need him.

The other woman, in treatment for 6 years, described her character as "A strong man, good looking, confident, smart, forceful and persistent."

Meeting Patients Where They Are At

Interest in having someone act out their dialogues was split down the middle with four participants saying "yes" and four saying "no", and one participant saying "no/maybe". Of the four who said "no", two commented that they "had done it enough", or "go through it every day". There was no apparent correlation between treatment duration or age, and interest in having their scene acted out.

CHAPTER V

DISCUSSION

The Process

The majority of participants claimed that the exercise was easy and they seemed to grasp the concept of creating a character and writing a dialogue. Those with the shortest amount of time in treatment experienced a more difficult time following the process. The two participants in treatment for the shortest duration expressed the most difficulty with the exercise. Both of these women also commented that they were unfamiliar with their eating disorder and/ or themselves. It appears that duration in treatment may be linked to an understanding of the self and the eating disorder which in turn affects the participant's ability to follow the dialogue writing process. The process may require a more advanced level of personal insight.

The use of role reversal in psychodrama aides in the exploration of different aspects of the self which may encourage a better understanding of the self and of the eating disorder in a manner which does not compromise the externalizing aspects of dialogue writing and might couple well with the dialogue writing process. Additionally, studies by Padula and Rees (2006), Riordan (1996), Frayne and Wade (2006), Pennebaker & Beall (1986), Gortner, Rude and Pennebaker (2006) point to the efficacy of creative and expressive writing which explores emotional topics; dialogue writing touches on emotional issues, but does not provide an in depth exploration of emotions which might provide the insight necessary to more easily complete the dialogue writing

process. Monologue writing, which can facilitate a deeper analysis of emotions, coupled with dialogue writing might provide the extra insight necessary to enhance the dialogue writing process.

Also, the issue of creative ability surfaced. Although she ranked the ease or difficulty of following the instructions as moderate, the participant who claimed that she was not creative expressed that it was difficult for her to conceive of her eating disorder as a character. This may become an issue for some people who feel that they are not imaginative enough to engage in a creative exercise. Care should be taken, particularly with a population prone to perfectionism, to frame the intervention as “an exercise” and not as a “creative” exercise or project, with emphasis placed on the therapeutic process as opposed to the creation of a product. On this note, although half of the participants expressed an interest in seeing their dialogue acted out, it may be advantageous to offer this possibility at the end of the process so that participants do not feel pressured to create a performance worthy dialogue, concentrating on the product rather than the therapeutic process of the exercise.

Adjustments to the instructions should include creating more concise, less wordy language as was indicated by a small majority of the participants. Further studies might consider excluding the examples written into the instructions; however, this may compromise the participant’s comprehension of the exercise so care should be taken to maintain enough material to ensure clarity.

Externalizing

Based in Narrative Therapy and the externalization of the problem, the participant’s ability to externalize their problem through the successful creation of a

character separate from themselves emerges as one of the most important aspects of the dialogue writing process and may be most feasible with individuals who have been in treatment for a longer length of time. White and Epston champion the externalization of the problem in narrative therapy as a way “to experience a sense of personal agency” (White & Epston, 1990, p. 16). Those participants who successfully externalized their eating disorder described this type of self empowerment with comments like, “Made me feel like I can de-attach from it,” and feeling “that I could actually talk back” (to the eating disorder as personified in her character), and another described the experience as “powerful”.

Of those who were unable to fully externalize their eating disorder and create a character that represented it, some still experienced a sense of separateness from their eating disorder with comments like, “I learned that my eating disorder is separate from me”, and “I am more aware of my Eating Disorder and how twisted you can get with yourself and your Eating disorder”. Therefore, even if the participant cannot fully experience the personal agency that accompanies the complete externalization of their eating disorder, it appears that they still gain at least a preliminary understanding of the concept of externalization. This initial comprehension of the eating disorder as separate from the self emerges from the power of creating a unique character from one’s own imagination as opposed to a pre-existing image as used in Padula and Rees’ (2006) study where archetypal images were chosen by the therapist for use by the participants. Even though some women used themselves as their character, they were able to describe that character and give it distinct characteristics which encouraged them to own the image and provide an initial understanding of the process of externalization.

Although 4 women in treatment 10 months or less were able to externalize their eating disorder, the three who were unable to externalize were among those in treatment the least amount of time – 12 weeks or less. Those in treatment for more than 10 months were all able to successfully externalize their eating disorder. This suggests that while lengthy treatment duration is not necessary for the ability to externalize, it probably increases the likelihood that someone will have this capacity. This may be due to previous experience with externalizing techniques in treatment and a newly emerging distance or detachment from the disorder.

The three women who did not create a character separate from themselves all used themselves as the representation of their eating disorder. This corresponds with Madigan and Goldner's theory that conventional, non-externalizing concepts of eating disorders view them as "living inside" (1998, p. 382) the person. The idea that the person *is* the disorder is not unique to eating disorders; it is the basis for the conventional medical model which often pathologizes the person. It is, therefore, not surprising that these women might view their eating disorders as one with their selves.

Similar to Zimmerman and Shepherd's (1993) experience with treating bulimia by externalizing it, the majority of participants experienced a positive change in their attitude towards their eating disorder during the process. Several women expressed a readiness to say goodbye, or let their eating disorder go. Unlike Dare and Crowther's (1995) assertion that the task of psychoanalytically informed psychotherapy help the patient see themselves as "both tyrant and victim" (p. 302), the externalization process inherent in dialogue writing creates an atmosphere where participants can exclaim "How ready I was to say goodbye!!!", express a new awareness of their eating disorder, and

gain a sense of empowerment over their eating disorder. It is through the externalization process in the dialogue writing that these women were able to come to these conclusions. Had they used Dare and Crowther's technique of fusing themselves with their eating disorder it is highly unlikely these types of transformations would emerge. A person who believes they are one in the same with their eating disorder could not say goodbye to their eating disorder without simultaneously saying goodbye to their selves. Additionally, awareness of the eating disorder becomes muddled with self concept without the externalization piece. Empowerment over the eating disorder also becomes problematic. Without separating the self does the person feel as though they must have power over themselves? If so, the question remains how do you simultaneously empower and disempower yourself?

In McLeod's (2006) article on narrative therapy and Lock, Espton, and Maisel's report on anorexia they discuss the "voice" of anorexia. Three women in the dialogue writing study commented that they identified with the voice of their eating disorder. Two explained that they recognized that the voice existed prior to the exercise. The other woman expressed that giving the character a voice gave it a tangible quality, feeling that she could "actually talk back". These women had drastically different durations of treatment – one 6 years, one 10 months and the other 4.5 weeks, so identification with the "voice" is not necessarily correlated to treatment duration.

Power and Control

The issue of power and control emerged frequently throughout the responses as McNamara, Chur-Hansen, and Hay found in their 2008 study. Congruent with feminist theory, the participants seemed to struggle with the concept of personal power and

control verses the power and control exerted by their eating disorder. No correlation existed between treatment duration and the women's sense of personal power and control. Seemingly contradictory statements like those made by the woman in treatment for 3 weeks, describing her character as having "all of the control" and "powerful", and then in response to how it felt to give a voice to the character she also wrote "powerful", and then, "I learned that I am strong enough and determined to say goodbye for good" when asked what she learned about herself during the exercise. This struggle between the power and control exerted by the eating disorder and a personal sense of empowerment becomes very apparent in the responses. Participation in the dialogue writing process and the subsequent examination of one's own responses provides an opportunity to witness this phenomenon as White and Epston's comment suggests "a consciousness of one's production of one's productions, provides for a context of reflexivity" (1990, p. 18).

Contradictions

Proponents of CBT, Mountford and Waller (2006) claim "that there is less likelihood that the individual patient will be able to work towards resolving confused feelings, motivations, and behaviors" (p. 534), in a therapy utilizing externalizing techniques. Although, many of the participants in the dialogue writing exercise seemed to contradict themselves in terms of their experience with power and control and their eating disorder, the dialogue writing process may provide the ideal stage to address the confusing aspects of the disorder. The three women who described contradictory relationships with their disorder describing it as toxic and healthy, abusive and loving, and something to both love and hate simultaneously also exemplify the confusing aspects of eating disorders. All three of these participants had been in treatment for 10 months or

less which may have contributed to the confusing nature of their relationship with their eating disorder. According to The Mayo Clinic, the etiology of eating disorders is rooted in biological, psychological and sociocultural factors, contributing to its bewildering nature. Additionally, feminist theory expresses the confusing and opposing forces exerted upon women with eating disorders as discussed by Padula & Rees, (2006) “In the life of a woman with disordered eating there is a battle of opposites” (p. 66). The fact that dialogue writing provides the participant with a written record of their often perplexing and contradictory statements provides the perfect opportunity to confront those contradictions, analyze, and process them.

The role playing described by Schaefer in her book *Life Without Ed* (2004) may provide a similar opportunity for externalizing and conversing with the eating disorder; however, given the contradictions reflected in the dialogue writing questionnaire, confusion and ambivalence particularly around issues of power and control seem prevalent for this population, necessitating a more concrete technique like dialogue writing.

Emotional Response

Riordan’s 1996 study of therapeutic writing where he espouses that creating fictional characters to explore distressing topics alleviates negative emotions seems to contradict my findings that dialogue writing does conjure some difficult emotions for participants; all but one of the participants reported experiencing at least one negative emotion during the exercise. Most of the participants reported experiencing a mixture of emotions during the exercise. Amount of time in treatment did not seem to affect the type of emotions experienced. Three participants experienced primarily positive emotions,

with one expressing only positive feelings. However, only one of the women expressed only negative emotions in response to the exercise; therefore, there may be some validity to the claim that creating a fictional character buffers some of the potentially negative emotions experienced when writing expressively about a difficult topic like eating disorders.

The potentially distressing nature of expressive writing surfaces in the literature about expressive writing and eating disorders. Schmidt, Bone, Hems, Lessem & Treasure, (2002) concluded that the participants in their therapeutic writing study found the tasks difficult to complete because the process was too distressing. Of those who participated in the dialogue writing study, a small majority expressed a mixture of positive and negative emotions experienced during the exercise with two participants claiming a primarily positive emotional experience. None of the participants felt negative emotions exclusively and no respondents suggested that the exercise was too distressing to complete, although one participant alluded to emotional difficulty in regards to the process.

Attitude

All but one participant described a change in attitude towards their eating disorder as a result of the exercise. The participant with the shortest treatment time, 7 days, appeared to have the greatest change in understanding of her eating disorder claiming twice that she was more aware of her eating disorder as a result of the exercise. By creating a new narrative through the dialogue writing process, the participants seemed to have generated new stories for themselves as described by Epston and White (1990).

Characters as Abusive Men

Two participants described their eating disorders as attractive, abusive men, additionally, the woman in treatment for 7 days who used herself as her character used the term “him” when referring to her eating disorder at the end of the questionnaire. All of these women had been in treatment for drastically different amounts of time – 7 days, 10 months and 6 years, so there does not seem to be correlations between the length of treatment and the view of the eating disorder as an abusive man. I do not know if any of these women had experienced abuse in their lives, although with nearly three quarters of people with eating disorders having experienced trauma it is possible that there may be some correlation. Feminist theory might explain this phenomenon as a metaphor for a patriarchal society which entices women to have the perfect body even at the expense of their health.

Also, in line with feminist theory, the dialogue writing process does not emphasize weight management, a modality that Malson, Clarke and Finn (2008) found to perpetuate the objectification of the woman and, thus, exasperate the eating disorder; none of the dialogue writing participants mentioned their weight in any of their responses.

Meeting Patients Where They Are At

With the desire for having their dialogues acted out by others split between the participants, giving the option at the end of the exercise may be the most beneficial to participants. As was previously stated, in order to avoid a preoccupation with creating a perfect product for presentation, it would be recommended to not mention this option at the beginning of the exercise.

The dialogue writing process meets people where they are at without attempting to convince them to change. Like motivational interviewing, dialogue writing allows the change to come from the participant at her own pace and in her own unique manner without judgment. This is particularly evident in the broad range of responses. Some participants announced their intention to say goodbye to their eating disorder while others admitted that they were not quite prepared to leave it behind.

Limitations of the Study

The limitations of this study include a small number of participants and a lack of direct contact with them. It is difficult to make statistically significant conclusions about issues such as length of treatment and ability to follow the dialogue writing process with a total of 9 participants. Due to the lack of direct contact with the participants, elaboration of answers on the questionnaire became impossible. Due to the short and sometimes incomplete responses, specific conclusions were often impossible to make.

Additionally, despite attempts to make contact with the clinician who administered the exercise, we were unable to communicate in regards to the post exercise discussion. I was also unable to receive feedback from the clinician as to her experience with administering the exercise.

Also, information about prior treatment modalities and how they may have affected the participants' experience with the exercise was not available. It is possible that many of the participants had experience with externalizing therapies which would have made the process easier for them to understand.

Contributions to the Field of Social Work

Studies by Goldner and Madigan, Zimmerman and Shepherd, and Weber, Kierynn and McPhie all point to the effectiveness of externalizing therapies in the treatment of eating disorders. While the analysis of data in the dialogue writing study concentrated more on the feasibility of the intervention, participant responses suggest that the exercise provided them with an opportunity to externalize their eating disorder in a unique and potentially therapeutic manner. The majority of participants in the study were able to fully externalize their eating disorder, with the minority still able to take initial steps towards an understanding of the externalization process. White and Epston (1990) state that “when persons seek therapy, an acceptable outcome would be the identification or generation of alternative stories that enable them to perform new meanings, bringing with them desired possibilities – new meanings that persons will experience as more helpful, satisfying, and open-ended” (p. 15). The majority of participants reported an ability to create a different scenario that potentially brought new meaning to their relationship with their eating disorder. Dialogue writing could be a very useful tool for clinicians in the treatment of eating disorders, not only as an adjunct to other therapies, but as an introduction to the externalization process which appears to have great potential with this population.

Conclusion

The notorious difficulty in treating eating disorders may arise from the complex etiology of the disorders, arising from sociological, psychological and biological factors. Dialogue writing as an intervention for eating disorders engages with both the sociological and psychological factors inherent in the conditions. Through the

externalization process, participants may gain insight into the origins and processes which contribute to the seeming power and control which the disorders exert over them.

This study sheds light on the dialogue writing process and its strengths and weaknesses; specifically, illuminating the need for adjustments to the presentation of the instructions. Additionally, the study indicated the intervention's effectiveness as a tool in externalizing which repeatedly arises in the literature as a salient ingredient in the treatment of eating disorders. The study also exposed dialogue writing's ability to engage participants with issues of power and control. Its illumination of the contradictions that seem to arise from the disorders' distortions of thought processes also became evident and may present an opportunity for patients to witness and confront these distortions. Participants' emotional responses to the exercise were explored, as well as their changes in attitude toward their eating disorder. Finally, evidence of the intervention's ability to meet patients where they are at in their own therapeutic process surfaced.

This study laid the foundation for adjustments to the presentation of the exercise and further studies into its effectiveness as a tool in the treatment of eating disorders. The successful pilot of the study using anxiety as the presenting problem also suggests the flexibility of the dialogue writing exercise. Dialogue writing may be a useful tool for clinicians working with patients with eating disorders and has promise as an intervention with a variety of other disorders.

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Appendix A:
Human Subjects Review Approval

February 8, 2009

Andrea Harbeck

Dear Andrea,

Your revised materials have been reviewed and they are now complete. We are happy to give final approval to this most interesting study. I was wondering, are the dialogues going to be shared with you?

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Caroline Hall, Research Advisor

Appendix B:
Informed Consent Form

March 31, 2009

Dear Potential Research Participant:

My name is Andrea Harbeck. I am conducting a qualitative research study to determine if a new exercise that uses playwriting techniques in the treatment of eating disorders is doable, and what if anything people learn about themselves and their eating disorder through the exercise. The clinician who runs the group at The Eating Disorders Center of Denver will walk participants through the writing exercise which will be a required part of the group for two to three sessions, depending on how long the process takes to complete. The study itself involves participants filling out a short questionnaire after the exercise that asks specific questions about the process and how it affected you. The data will be used for my Master of Social Work thesis at Smith College School for Social Work and future presentations and publications.

Your participation is requested because you have been identified as a person with an eating disorder who receives treatment at The Eating Disorders Center of Denver and are a participant in the group chosen by the Center to complete the exercise. If you choose to participate, one of the clinicians from The Eating Disorders Center of Denver will ask you whether or not you want to fill out the questionnaire following the exercise. While the exercise will be a regular part of the group, filling out the questionnaire will be entirely voluntary. The exercise will have you write out a dialogue, or conversation between a character that represents yourself and a character that you create who will represent your eating disorder. The exercise will take up two to three group sessions, depending on how much time participants need to complete the exercise. The clinician will then distribute the questionnaire after the exercise to those participants who agree at that time to fill out the questionnaire and sign this Informed Consent. The questionnaire will ask you about the ease, or difficulty of the exercise and what, if anything, you learned about yourself or your eating disorder through the exercise. It is estimated that completion of the questionnaire will take 20 – 30 minutes, but the time taken to answer the questions is entirely up to the participant. Also, I will ask you to provide demographic information about yourself, like your age, your gender and how long you have been in treatment.

The potential risk of participating in this study may be that while you examine the affects the exercise had on you as you fill out the questionnaire you may encounter some difficult emotions. In case you feel the need for additional support after participating in this study, you are encouraged to bring the issues up with your individual clinician.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to the knowledge of dialogue writing in the therapeutic process. It is my hope that this study will help social workers develop a new tool for use in the treatment of eating disorders. You may also benefit from receiving the opportunity to share your experience and gain a new perspective about how your eating disorder affects you and your relationship to your eating disorder. The questionnaire will ask you to examine any new insights that you may have gained about yourself and your eating disorder during the exercise, and so might enhance your experience of the exercise and allow you to gain additional benefits from the exercise. Those benefits might include a better understanding of how the exercise affected you and what, if anything, you learned about yourself and your eating disorder by doing the exercise.

Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as no names or identifying information will be in the reporting of the data. Initially, the signed Informed Consent will be attached to your questionnaire and remain associated with it for two weeks in case you decide to withdrawal from the study after completing the questionnaire. Therefore, your identity will be associated with the questionnaire for those two weeks, but will not be used in any reporting of the data. The data may be used in other education activities as well as in the preparation for my Master's thesis. My thesis advisor will also have access to the data, but will not know your identity and will keep all information confidential. In publications or presentations, the data will be presented as a whole and any quotes will be carefully disguised. Your confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of three years and after three years it will be destroyed unless I continue to need it in which case it will be kept secured until no longer needed and then destroyed. Other members of the group will have knowledge of your participation in filling out the questionnaire and, therefore, the confidentiality of your participation cannot be guaranteed; however, only myself, the clinician running the group and my advisor, who will not know your identity, will have access to your answers.

Your participation in completing the questionnaire is completely voluntary and will not affect your treatment. You are free to refuse to answer specific questions and to withdraw from the study at any time during the two weeks after you fill out the questionnaire. If you decide to withdraw, all materials pertaining to you will be immediately destroyed. If you have additional questions about the study or wish to withdraw, please feel free to contact me at the contact information below. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Andrea Harbeck
1461 S. Magnolia Way
Denver, CO 80224

aharbeck@email.smith.edu
303-325-4049

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

Appendix C:
Confidentiality Pledge for Clinician

As the clinician administering the questionnaire in regards to the dialogue writing exercise used in my group at The Eating Disorders Center of Denver, I pledge to keep confidential the identity of those who fill out the questionnaire, and the contents of their answers.

Furthermore, I agree not to coerce any member of the group into filling out the questionnaire, or to influence their answers in any way.

Clinician's Signature

Date

Researcher's Signature

Date

Appendix D:
Letter to Human Subjects Review Board

To whom it may concern,

The Eating Disorder Center of Denver has freely chosen to use Andrea Harbeck's dialogue writing process as part of one of our regularly scheduled groups. Groups involve a variety of exercises that we may choose from. We feel that the dialogue writing exercise fits in well with our treatment modalities and will provide a new and interesting opportunity for our patients to explore their eating disorder. We would be interested in utilizing this exercise even if it were not associated with Andrea's research project. Please contact me if you have any questions.

Tamara Pryor, Ph.D.
Clinical Director
Eating Disorder Center of Denver
720-889-4217 Direct Line
303-771-0861 Front Desk

Appendix E:
Dialogue Writing for Eating Disorders

Participants will write out a dialogue between themselves and a character which they will create that is the personification of their eating disorder. The following are the instructions given to the participants.

1. Sit for a moment and think about the eating disorder and what shape or form it would take if it were a physical being. It could be a person, a monster, a blob etc.
2. Give this being a name.
3. Imagine a scene where the eating disorder often shows up and has a lot to say to you. It could be at a restaurant, looking at yourself in the mirror, etc.
4. Write this scene out in detail. Who is there, what are they doing, what do your physical surroundings look like?
5. The eating disorder has a job to do, something besides just making you feel a certain way or making you skinnier. Your eating disorder might be taking your thoughts and feelings and distorting them or blowing them out of proportion. Some thoughts might be something like, "I am not happy with myself." The eating disorder might take that thought and distort it and blow it out of proportion telling you that you shouldn't be happy with yourself because you are too fat. It might be creating "solutions" to your problems like throwing up will take make you feel less anxious. It might be taking the ideal of thinness and blowing it up and out of proportion. Write down eating disorder's job.

6. Imagine the eating disorder has a machine which it uses to carry out its task. Maybe it is a giant tube that sucks the rational thoughts out of your head and twists them around until they come back out distorted and exaggerated. Write down a description of this “machine”.
7. Come back to the scene that you described.
8. Imagine the eating disorder, the physical being that you described enters into this scene.
9. Your first line of dialogue will be the eating disorder greeting you. Write down the name of your eating disorder, a colon, and then the eating disorder’s greeting to you. What would it say to you?
10. The eating disorder then goes about doing its job. Write a description of what the eating disorder does with its machine. If it is distorting your thoughts, or creating “solutions” to your problems then write out each thought or problem and then the distorted thought or “solution” that comes out of the machine. So if one of your thoughts was “I am not happy with myself” write that out as your line of dialogue and then the next line will be the eating disorder using its machine to distort your thought by saying something like, “You shouldn’t be happy with yourself because you are too fat.”
11. Your next line of dialogue will be you. Write your name and a colon and ask the eating disorder why it does what it does.
12. Imagine there is a giant hole within you. This hole might represent an insecurity, or a feeling of emptiness, or something that is lacking in your life or within you. It is eating disorder’s job to fill that hole with whatever it is coming out of its machine. Have the eating disorder describe the hole it is filling and why it feels it needs to fill it.

13. Your next lines of dialogue will be you telling the eating disorder off. Tell it exactly what you think of it and its job.
14. Next, the eating disorder defends itself.
15. Continue this conversation between yourself and the eating disorder, with the eating disorder defending itself, explaining why it feels it has to do what it does and you telling it what you think of it.
16. End your dialogue by telling the eating disorder that you no longer need its services. Tell it you will keep its machine and use it whenever you need it to fill the hole within you, but that you can run it yourself. Your machine will be reworked now coming up with positive things about you that it will use to fill the hole. Go back to your thoughts, feelings or solutions that the eating disorder put through its machine and put them back through your new machine and have the machine spit out positive responses to those thoughts, feelings, or solutions. For instance, if your thought was “I am not happy with myself”, then put that thought through the new machine and have it come out with something positive about you.
17. Say goodbye to your eating disorder. End the scene with a description of your eating disorder leaving.

Appendix F:
Questionnaire

Please answer the following questions to the best of your ability about the dialogue writing exercise that you just completed.

- a. What is your gender?
 - b. What is your age?
 - c. How long have you been in treatment for your eating disorder, including treatment outside of the (Clinic where receiving treatment)?
-
1. Please describe how easy or difficult it was to follow the instructions during the exercise.
 2. Please describe how easy or difficult it was to understand the explanation of how to create a character who is representing your eating disorder.
 3. What would have made the instructions easier to understand?
 4. Tell me about the character you created.
 5. Tell me about how it felt to give a voice to this character.
 6. What did you learn about your eating disorder during this exercise?
 7. What did you learn about yourself during this exercise?
 8. What did you learn about your relationship with your eating disorder during this exercise?
 9. Would you want to see someone act out your scene?
 10. Describe any positive or negative emotions you experienced during this exercise.