ADOLESCENT GIRLS WITH LOW BODY-ESTEEM: A NARRATIVE THERAPY COUNSELING GROUP

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Abstract

The purpose of this paper was to propose an early intervention/prevention counseling group for adolescent girls with low body-esteem. The environmental influences that contribute to the development of low body-esteem were discussed along with the psychological, biological, and social consequences that develop in adolescent girls. A review of the literature documented that the use or narrative therapy integrated with art therapy and psychoeducation in a counseling group is a suitable approach for treating this population. The proposed 12-week narrative therapy counseling group is designed to support adolescent girls to re-author their self-narratives such that positive body-esteem is cultivated, the use of unhealthy weight control behaviors is reduced, and the girls are empowered with the knowledge necessary for them to sustain a healthy life.

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Chapter I

Introduction

The standard of female beauty in the United States has evolved dramatically over the last several decades and has resulted in a nation-wide, female obsession with an unrealistically thin body (Duba, Kindsvatter, & Priddy, 2010). The societal acceptance of this ideal image places incredibly high and unrealistic expectations on women to achieve an extremely thin physic that is unobtainable by most (Wolszon, 1998). This obsession with and subsequent pressure for physical perfection have been passed down to children and are having devastating effects on the well-being of adolescent girls in the United States (Collins, 1991; Harrison & Hefner, 2006; Kluck, 2010; Neumark-Sztainer et al.,2010). Most girls are socialized to be thin and fear becoming fat, and some girls fear remaining overweight. They grow up idealizing models, actresses, and athletes and most girls become very critical of their own bodies when they do not measure up to what they see in the media; as a result, they grow up disliking their bodies and developing low body-esteem (Brausch & Muehlenkamp, 2007; Dori & Overholser, 1999; Harrison & Hefner, 2006; Kostanski & Gullone, 1998).

This chapter discusses the background and prevalence of body-image challenges by reviewing the literature that considers the environmental influences to which adolescent girls are exposed and the subsequent biopsychosocial outcomes. Chapter I also introduces the purpose of this project, which includes proposing a theoretically sound and research supported counseling group for adolescent girls with low body-esteem. Chapter II briefly summarizes the theoretical models employed in the proposed intervention as well as the research that supports the use of these approaches with adolescent girls with low body-esteem; it also considers some of the intervention strategies that have been found to help

mitigate these outcomes. Chapter III proposes and discusses in detail a group counseling intervention for adolescent girls struggling with low body-esteem. This intervention integrates narrative therapy with psychoeducation and with the creative arts as an alternative modality of self-expression. Chapter IV concludes this paper with a discussion of the project and its implications for counselors and for future research.

Background of the Problem

To better understand the need for a preventative intervention, it is imperative to understand the prevalence of body-image dissatisfaction among girls in the United States, and what factors influence many teen girls to become desperate to achieve an extremely thin body that some develop unhealthy weight control behaviors and many become tremendously unhappy with the shape of their bodies. The prevalence of body image challenges, the environmental influences that lead to unhealthy body image in adolescent girls, and the biopsychosocial outcomes that result are discussed in this section.

Definitions. Body image is an expression that refers to how a person perceives his or her own body (National Eating Disorder Association, 2008). Body-esteem is the degree to which someone values his or her body or appearance (Mandelson, Mandelson, & White, 2001); when a person is unhappy with his or her perceived bodily shortcomings, this is referred to as body dissatisfaction (Ferguson, Winegard, & Winegard, 2011). It is common for people who struggle with body dissatisfaction to also have low body-esteem and low self-esteem (van den Berg, Mond, Eisenberg, Ackard, & Neumark-Sztainer, 2010), which increases a person's possibility of developing significant mental health problems, such as depression, anxiety, and suicidal ideations (Brausch & Muehlenkamp, 2007; Duba et al., 2010).

Prevalence of body image challenges. According to the National Eating Disorder Association (2008), 80% of women in the United States reported being dissatisfied with their bodies and over half of adolescent girls reported using unhealthy means of controlling their weight. In the early 1990s researchers found that 42% of girls in primary school wanted to be thinner (Collins, 1991) and that 81% were afraid of being "fat" (Mellin, McNutt, Schreiber, Crawford, & Obarzank, 1991). In a nationally representative study conducted by the Centers for Disease Control and Prevention (CDC) (2006), 13,953 teens in grades 9-12 in both public and private schools in all 50 states and the District of Columbia were surveyed and the results indicated that 64% of Hispanic and Caucasian and 53% of African American adolescent girls reported attempting to lose weight by utilizing a range of weight loss methods in the 30 days preceding the study. In addition to the pressure to be thin is the growing trend of weight gain among some youth; in 2008, the CDC reported that more than one-third of children and adolescents in the United States were overweight or obese. This report also indicated that, among boys and girls aged 12 to 19 years old, the rate of obesity had increased to 18% nationally.

The phenomenon of developing low body-esteem is not unique to a single gender or group of people; in fact, this problem has been found in both males and females across cultures and socioeconomic groups in the United States (Bearman, Presnell, Martinez, & Stice, 2006; CDC, 2006; Field et al., 2005; Neumark-Sztainer et al., 2010; Neumark-Sztainer, Story, Hannan, Perry, & Irving, 2005; van den Berg et al., 2010). It is not within the scope of this paper to focus on boys or men, but it is important to note that this problem exists cross-culturally among teenagers and adults, within both genders, and across all classes, in the United States.

Environmental influences. There has been much debate over and research done to investigate what contributes to adolescent girls' desire for an extremely thin body type. Most sources focus on the media's influence and/or pressure from parents and peers. This section examines the history of the idealized female body and the influence that the media and society have on adolescent girls' internalized desire for thinness.

History. In many cultures throughout history, having a larger body was highly valued because it was a sign of good health and financial wealth. People made the assumption that if individuals were thin, it was because they were poor and could not afford enough food. This desire continued in the U.S. through the 1800s and into the early 20th century, when the more voluptuous women were seen performing in the theaters and posing for print media (Duba et al., 2010). This slowly began to change in the 1950s, with the introduction of the more slender model. During this time, both thin and voluptuous women were seen in the media and were considered beautiful and idealized by all. A complete shift occurred in the 1960s and 1970s, when society began to value exclusively the beauty of a taller, straight-hipped woman who was leaner than the average woman in the United States. During the decades following this shift, the idealized body type has continued to be very thin and far removed from the average clothing size of U.S. women's size 8 (Duba et al., 2010).

Media. As stated above, over the last few decades, most female models portrayed in the media are much thinner than the average woman in the United States. According to the National Association of Eating Disorders (2005), the average fashion model is thinner than 98% of U.S. women. This association stated that the average height for U.S. models is 5'11" and their weight is 117 pounds; however, the height and weight of the average women in the U.S. is 5'4" at 140 pounds. Women portrayed in the media define the standard of beauty as

well as what is desirable in the United States; however, according to the Kaiser Family Foundation (2004), one-third of the women on television in 2003 were underweight.

On average, girls ages 2 to 18 years old report an exposure of 6 hours and 20 minutes a day to all forms of media, including television, the Internet, print, music, and movies (Roberts, 2000). After surveying a racially diverse group of 257 preadolescent girls, Harrison and Hefner (2006) concluded that, across all racial backgrounds, the amount of television viewed by girls in grades 2-4 at the beginning of the study was strongly correlated with the girls' desire to have a thinner body one year later. In 2007, the American Psychological Association released a report on the "sexualization" of girls and concluded that the media is a significant contributor to the development of body dissatisfaction among girls and adolescents.

Society. A common counterargument to the notion that the media is responsible for the development of body dissatisfaction is the idea that genetic predispositions, families, and peers have a greater influence on adolescent girls' standard of beauty and, ultimately, on how they perceive their bodies. According to Ferguson and associates (2011), stronger evidence supports the idea that body dissatisfaction is caused more often by genetic predispositions and peer influence than by media exposure. They explained that women have cognitive and affective systems that regulate their perceived value to potential mates and that these systems can be genetically predisposed to be more or less sensitive; a greater sensitivity may result in an increased likelihood of body dissatisfaction. In an environment where receiving attention from potential mates is sought out in a competitive fashion by a woman's peers, body dissatisfaction may be intensified. Furthermore, adolescent girls receive messages from their parents, siblings, friends, and peers that continuously reinforce the importance of being very

thin. These messages come in the form praise for those who meet their standard of beauty and of criticism for those who do not meet these standards; it is also conveyed through discussions of diet and food selection. Some girls reported being criticized by family and peers about their bodies, while others internalized the message that it is important to be thin by observing others' dieting behaviors or hearing about other women's desire to be thinner (Kluck, 2010; Neumark-Sztainer et al., 2010). Neumark-Sztainer and associates (2010) found this to be true cross-culturally in their study of a multi-ethnic/racial sample of U.S. adolescent girls (28.4% African American, 24.4% Caucasian, 14.3% Hispanic, 23.0% Asian, 2.5% Native American, and 7.3% mixed/other).

Society in the United States, in general, is responsible for the messages that girls receive regarding the importance of being thin. Girls learn that the more attractive they are, the more social value they have (Duba et al., 2010). Research has found that beautiful women are better able to interact with and relate to others, therefore, making them more successful in developing relationships and acquiring resources. Duba and colleagues (2010) also discussed that beautiful women have more doors opened for them and are better able to influence men to relinquish control over power and resources. Adolescent girls observe this phenomenon and internalize the importance of investing in the development of their appearance and their sexual attractiveness in order to obtain a higher status (Duba, et al., 2010). However, this investment often comes at the cost of their physical, psychological, and social wellbeing.

Biopsychosocial outcomes. Due to the constant pressure from their environment to be thin in order to achieve society's standard of beauty and power, adolescent girls have internalized the desire to possess an extremely thin body, one that is naturally obtained by

only 2% of U.S. women (National Association of Eating Disorders, 2005). As a result of their desire to achieve such an unnatural figure, adolescent girls often develop unhealthy beliefs and habits that lead to poor mental and physical health. This section provides a review of the literature examining the beliefs, behaviors, and disorders that develop in adolescent girls as they attempt to achieve the ideal body type.

Beliefs. Research has found that girls begin to internalize a thin body ideal as early as preadolescence (Harrison & Hefner, 2006), and they develop a fear of becoming fat as young as ten years old (Collins, 1991). This internalization occurs as girls cognitively accept the thin societal standard of attractiveness as their own (Harrison & Hefner, 2006), and they believe that achieving this standard is the only way they will be perceived as beautiful and desirable by society. Girls also equate their ability to achieve this body type to their value as a person and their self-worth. Several studies have demonstrated that body image and body satisfaction are directly related to self-esteem; that is, if girls are dissatisfied with their bodies, then they are more likely to have lower self-esteem than girl who are comfortable with their bodies (Brausch & Muehlenkamp, 2007; Dori & Overholser, 1999; Kostanski & Gullone, 1998). Low self-esteem and body dissatisfaction can lead to unhealthy behaviors and to depression, anxiety, and suicidality.

Behaviors. As a result of their environmental stressors and internalized beliefs about their ideal body, adolescent girls implement a variety of unhealthy and dangerous behaviors as a means to control their weight or lose weight. Extensive research has found that girls participate in extreme weight control behaviors such as restrictive dieting, excessive exercising, using diet pills or laxatives, smoking cigarettes, fasting, and vomiting after eating as a result of the pressure they receive from their environment to be thinner (Kluck, 2010;

Neumark-Sztainer et al., 2010). Kluck (2010) found that adolescent girls were more likely to partake in disturbed eating behaviors, specifically behaviors associated with bulimia nervosa, as a result of parental criticism and comments about their weight and/or size. Similar findings have been reported as a result of television and magazine exposure in preadolescent and adolescent girls (Harrison & Hefner, 2006). Adolescent girls use products such as steroids, creatine, and growth hormones on a weekly basis in an effort to look like the women portrayed in the media (Field et al., 2005). The CDC (2006) reported that roughly 3% of high school aged girls, nationally, have used steroids in their lifetime. Liechty (2010) and Shisslak, Crago, and Estes (1994) found that, if untreated, adolescent girls continue to engage in these unhealthy weight control behaviors and often adopt increasingly more dangerous behaviors.

Low body-esteem and the use of unhealthy and risky weight control behaviors such as these have also been linked to an increase in suicide ideation and suicidal behaviors in adolescent girls (Brausch & Muehlenkamp, 2007; Kim, Moon, & Kim, 2011). Specifically, Kim and colleagues (2011) found that girls who had an unrealistic body image, such that they perceived themselves as weighing more than they actually did, had a significantly high rate of engaging in suicidal behaviors. Brausch and Muehlenkamp (2007) reported that low body-esteem is a greater predictor for suicide ideation in adolescent girls than many other known predictors.

Disorders. Although more research is needed to more carefully define the relationship between low body-esteem and depression or anxiety, studies have demonstrated that body satisfaction is correlated with higher self-esteem and inversely related to depression, anxiety, and eating disorders among adolescents (Cromley et al., 2012; Green et

al., 2009). Furthermore, helping adolescents who are overweight or obese, or who have unhealthy weight control behaviors by focusing on ways to enhance their self-esteem and body image, may help to prevent or reduce depressive symptoms (Green et al., 2009; Martyn-Nemeth & Penckofer, 2012).

Adolescent girls with low body-esteem are also at an increased risk for developing a partial eating disorder, also known as a threshold or subthreshold eating disorder; an eating disorder not otherwise specified; or a full-syndrome eating disorder (Shisslak et al., 1994; Stice, Marti, & Durant, 2001). According to a review of the literature done by Shisslak and colleagues (1994), several studies have confirmed that 20 to 25% of pathological dieters who progress in the use of unhealthy weight control behaviors, from mild to more severe, develop a partial or full-syndrome eating disorder within one to two years following their initial evaluation (Shisslak et al. 1994). This risk significantly increases for adolescent girls who also report symptoms of depression (Stice et al., 2001).

In the United States, there are approximately 24 million people suffering from an eating disorder (National Association of Anorexia Nervosa and Associated Disorders, 2012). According to Sullivan (1995), when compared to all other mental health disorders, eating disorders have the highest mortality rates. In 2009, the crude mortality rates for anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified was 4%, 3.9%, and 5.2% respectively (Crow et al., 2009).

Statement of the Problem

A high percentage of adolescent girls in the United States are struggling with low body-esteem, a low regard for their own physical appearance, across ethnic backgrounds. The CDC (2006) and the National Eating Disorder Association (2008) reported that more

than half of teen girls partake in a variety of weight control behaviors, many of which are unhealthy and pose significant health and social-emotional risks. Adolescent girls have internalized an ideal body type that is extremely thin and significantly disproportionate to the average woman in the U.S. (National Association of Eating Disorders, 2005).

As a result of an almost continuous exposure to underweight women in the media (Kaiser Family Foundation, 2004) and through messages they receive from family, peers, and society, girls learn that a very thin body type is not only attractive and highly respected, but necessary for attracting a mate and for optimizing opportunities (Duba et al., 2010; Ferguson et al., 2011). In an attempt to achieve the very thin body type portrayed in the media, adolescent girls employ extreme weight control behaviors, including restrictive dieting, fasting, consuming diet pills, vomiting after eating, and using steroids (CDC, 2006; Harrison & Hefner, 2006; Kluck, 2010; Liechty, 2010; Neumark-Sztainer et al., 2010; Shisslak et al., 1994). The development of high levels of body dissatisfaction and low body-esteem in adolescent girls is often coupled with extreme weight control behaviors and has been found to increase adolescent girls' likelihood of developing an eating disorder (Shisslak et al., 1994; Stice et al., 2001), of developing higher rates of depression and/or anxiety (Cromley et al., 2012; Green et al., 2009), and of experiencing suicidal ideation and behaviors (Kim et al., 2011). Although the phenomenon of low body-esteem is not exclusive to women and girls, the purpose of this paper is to focus on how it can be prevented and changed in adolescent girls.

Purpose and Significance of the Project

This paper has two purposes. One is to define the problem of body dissatisfaction among adolescent girls and the subsequent biopsychosocial risks. Chapter I has summarized

a review of the literature examining the history of idealization of thin body types for women and environmental influences to which adolescent girls are exposed that shape the development of the internalized stories that they tell themselves about their bodies. Furthermore, the biopsychosocial outcomes that develop in adolescent girls as a result of these unrealistic myths have been summarized, including the devastating effects that these beliefs and values can have on some girls' well-being. This review aims to assist counselors to better understand these influences and potential outcomes as they consider appropriate interventions and ways to integrate psychoeducation into the proposed prevention counseling group.

The primary purpose of this project is to propose a preventive counseling group for adolescent girls who may be struggling with low body-esteem. The group is guided by the theory of narrative therapy (Carr, 1998; Corey, 2009; Etchison & Kelist, 2000; White & Epston, 1990) and integrates art therapy (Frisch, Franko, & Herzog, 2006; Huss, Nuttman-Shwartze, & Altman, 2012; Malchiodi, 2007) with psychoeducation. This intervention is designed specifically to assist adolescent girls to learn how to recognize environmental influences that shape their beliefs about their bodies and their self-worth, to help them to develop a positive body-esteem, and to help them adapt healthy behaviors that will support their physical and mental health.

The proposed intervention consists of a closed therapy group for adolescent girls, aged 14 to 18 years old, who have self-identified or who have been identified by another as having negative body-esteem. The overall goals of the group are to improve how the participants feel about themselves and their bodies, to prevent or reduce the use of unhealthy weight control behaviors, and to instill healthy lifestyle habits. To accomplish these goals,

the group is guided by narrative therapy to help the participants recognize the stories they tell themselves, to externalize the problem, to understand the reasons for their stories, and then to reconstruct new stories that allow for self-acceptance, healthy living, and inner peace (Carr, 1998; Padulo & Rees, 2006).

Narrative therapy assumes that individuals' identities are developed by their personal narratives and that challenges occur for people when their self-narratives are problem-saturated. Narrative therapy works to externalize the problem so that people are able to assess the effects the problem has on their lives, to gain an understanding of how it operates, to recognize the earliest accounts of this problem, to evaluate it, and then to choose their relationship to it moving forward (Carr, 1998; Corey, 2009; Kelley, Blankenburg, & McRoberts, 2002; Leahy & Harrigan, 2006; Weber, Davis, & McPhine, 2006; White & Epston, 1990). The end result is a new self-narrative, one that is more helpful and healthier.

Throughout each session, the integration of art therapy exercises is proposed as an alternative means of self-expression. Including the use of art, images, and symbols as a means for girls to identify and share their stories with others is intended to help participants to feel less vulnerable and a greater sense of control over the therapeutic process (Kelley et al., 2002; Padulo & Rees, 2006). Psychoeducation is integrated into the narrative, art therapy group, such that the counselor informs group members about various related topics, such as the risks of low body satisfaction and the United States' medical standards of health, including the need for proper nutrition, physical exercise, and adequate sleep. To ensure that accurate and quality information on these subjects is provided to the participants, it is recommended that, on occasion, experts be invited to the group as guest speakers to meet with the girls. Overall, the prevention group provides both the information and the

explorative work to support group members to feel empowered to develop their own standard of beauty, rejecting the unrealistic standard that has been established in the popular culture of the U.S.

The following chapter introduces and reviews the literature on narrative therapy and art therapy, psychoeducation (with a focus on healthy beliefs and behaviors), and group counseling with adolescent girls. This review supports the use of these approaches in a group setting with adolescent girls as an appropriate and beneficial intervention for achieving the overarching goals of increased body-esteem and behaviors that promote overall physical health and mental well-being.

Chapter II

Review of the Literature

In the United States, adolescent girls are experiencing a significant amount of body dissatisfaction and low body-esteem, ultimately leading to low self-esteem and increased depression and anxiety (Cromley et al., 2012; Green et al., 2009). One factor that contributes to body dissatisfaction is the continuous pressure girls receive from their environments to achieve the unrealistic societal standard of physical beauty. Many adolescent girls have internalized society's ideal body type as their own and, in striving to achieve it, more than half of girls in the U.S. report using a variety of weight controls behaviors, many of which are unhealthy and pose significant health and social-emotional risks (CDC, 2006; National Eating Disorder Association, 2008).

In Chapter II therapeutic applications are presented. Narrative therapy (Carr, 1998; Corey, 2009; Etchison & Kelist, 2000; White & Epston, 1990) and art therapy (Frisch et al., , 2006; Huss et al., 2012; Malchiodi, 2007) are introduced and supporting research is provided to demonstrate their ability to help facilitate change and promote positive mental health in adolescents and adults (Frisch et al, 2006; Hartz & Thick, 2012; Heenan, 2006; Leahy & Harrigan, 2006; Weber, Davis, McPhie, 2006). Psychoeducation is then introduced as an intervention to inform and educate participants in a psychotherapeutic setting about how to critically analyze the media, to engage in appropriate exercise, and to consume foods high in nutritional value, as well as about overall physical and mental health. A summary of the research supports the effectiveness of group therapy with adolescents (Corey, 2012).

Narrative Therapy

Narrative therapy, a postmodern approach to psychotherapy, was founded by Michael White and David Epston (1990) in the 1980s. Narrative therapy facilitates participants to explore the stories they tell themselves, gain understanding of their stories' origins, and re-author new stories that are congruent with their life experiences. It is a strength based and goal oriented model designed to help people identify the strengths and abilities of which they had been previously unaware as a means of creating change in their lives (Corey, 2009; Etchison & Kelist, 2000).

Theory. White and Epston (1990) stated that problems are developed and maintained in a social, cultural, and political context as a result of the oppressive language and beliefs that people use to construct their stories. While assuming the role of consultant, therapists aim to help clients deconstruct the meaning that they give to their lives, the language practices they use, and the power relationships in which they are a part. Power relationships, which implement strategies of isolation, evaluation, and comparison, unconsciously recruit people to lead the subjugation of their lives. These power relationships result in people internalizing societal standards that are often unobtainable and believing that by attempting to achieve them they are striving for happiness, success, and acceptance. This constant striving for excellence then leads to the development of self-destructive and self-defeating behaviors that have, in turn, been pathologized by mental health professions (Carr, 1998).

Narrative therapy implements eight interventions to help clients re-author the narratives or stories that they tell themselves. The first intervention is to externalize the problem: through the use of questions, therapists help clients to separate the problem from their identities. For example, a client may believe that she or he *is* depressed and can begin

to reframe her or his experience by stating that she or he *has* depression. This process guides people to discover a new awareness about how the problem affects their lives and their relationships, what control they have over the problem, and in what context they view the problem. Externalizing the problem creates a greater sense of internalized agency within clients.

Excavating unique outcomes is the second intervention. The goal here is to identify times when an outcome occurred that was unusual or unpredictable based on clients' original problem-saturated narrative. Unique outcomes are presented as opportunities for people to begin re-authoring their stories.

New or revised stories are further developed through the third intervention called thickening the plot. Thickening the plot requires clients to answer two kinds of questions, asked by the therapists: (a) landscape of action questions are intended to help clients map out events so that they can plot the sequences of events within the story, and (b) landscape of consciousness questions aim to provide meaning to the story. Mapping out the story allows for insight regarding motives, purposes, intentions, beliefs, values, and hopes to be gained both by clients and therapist (Carr, 1998; Corey, 2009).

The fourth intervention is linking new stories to the past and extending them to the future. During this phase in the process, therapists ask questions designed to help clients review their lives in order to assist them to find forgotten or marginalized times that are consistent with their new story. Clients can also imagine how experiences could have been different had their lives been directed by their new narrative. Clients and therapists also discuss possible future scenarios in clients' lives through the lens of their new narrative while

utilizing language that keeps all possibilities tentative as opposed to prescriptive; this allows for greater flexibility and openness to change in the future.

The fifth intervention is outsider witness groups. The probability of new stories taking root in the clients' lives is increased if they have witnesses to their process. This witness is someone who understands their problem, knows what clients can expect to encounter while working to live their new narrative, and provides support and coaching along the way.

During the sixth intervention, re-membering practices and incorporation, therapists help clients to identify supportive family and friends who share in their experiences and struggles and to learn how to incorporate these people into their lives as resources. Clients are encouraged to draw on these people for support and assistance in problem solving. In cases of grief and loss, clients work to re-member whom or what they lost and to find a way to keep a part of what or who was lost with them. This approach is differentiated from traditional grief and loss work that is designed to help clients work through the stages of grief until they are ready to say good-bye and separate themselves from the loss because it teaches clients that they do not have to let it go; rather, they can find a way to live in peace by keeping part of what they lost with them.

The seventh intervention is called taking-it-back practice. In this phase, therapists share about their clients or the clients themselves share their new insights, stories, and skills with other clients of their therapist or with other members of the community who are experiencing similar struggles. This process also allows for clients to hear how their participation in therapy has affected their therapist. Narrative therapy acknowledges that therapists are often just as affected by the therapeutic process as clients.

The eighth intervention of therapeutic documentation is an intervention that can be applied at any time and often throughout the therapeutic process as a means for therapists to facilitate, document, and praise change. These documentations help to reinforce what clients are learning in therapy and give them a symbolic way of carrying that into their everyday lives (Carr, 1998; Corey, 2009).

Research. Since the first publication of White and Epston's (1990) text introducing narrative therapy was released in 1990, much research has been conducted internationally to evaluate its effectiveness with various populations and for treating a variety of presenting problems. This body of research has revealed that narrative therapy is an appropriate approach for people across the lifespan; it is also effective in helping people to gain societal and personal awareness and insight, reduce symptoms of depression, change disordered eating behaviors, increase self-acceptance, learn new coping skills, and improve self-expression (Kelley et al., 2002; Leahy & Harrigan, 2006; Weber et al., 2006). More research on the usefulness of narrative therapy is still needed in order for its true potential to be understood; however, it has consistently been found to be an effective approach to facilitate positive and lasting change.

Narrative therapy for preventing body image issues. Leahy and Harrigan (2006) evaluated the effectiveness of using narrative therapy and psychoeducation as a means for preventing body image problems in women. They conducted a 7-week group counseling intervention for young, elite, female athletes training at the Australian Institute of Sport (AIS). The group participants consisted of a 15-member, Caucasian, ball-sports team. All of the women were between the ages of 17 and 19 years old with an average age of 18 years old. Participation in the "Healthy Body Image Program" had been widely accepted by both

coaches and athletes as a normal component of the sports psychology's psychoeducation annual workshop curriculum and as a requirement for participation at AIS; therefore, the selected girls had no hesitation about participating. Written anonymous feedback was provided one week after the final session. Participants had the opportunity to answer four open-ended questions regarding their experience in the group. Their answers were analyzed and the results showed that the use of narrative therapy was successful in facilitating a new awareness among the participants that body image concerns are not unique to one individual, nor are they a female pathology; rather, they are a product of the scripts that they had been given by society about the ideal body type (Leahy & Harrigan, 2006). Given the small sample and other limitations of this study, the results cannot be generalized to others; further research is needed to study the effects of narrative therapy for decreasing body dissatisfaction among young women and older teens.

Narrative therapy for treating eating disorders and depression. Weber and colleagues (2006) looked at the usefulness of a counseling group that implemented the use of narrative therapy as a means to help women struggling with an eating disorder and depression. Their group was compiled of seven, 20 to 39-year old, self-referred women from a rural region in northern New South Wales. Each woman reported struggling with an eating disorder for the last 5 to 23 years and that they are currently experiencing symptoms of depression. Women were excluded from the study if they struggled with overeating or binge eating, were unable to maintain a healthy weight, or had attempted suicide within the last three months. Each session was 2.5 hours long and supplemented the primary use of narrative therapy interventions with interventions consistent with motivational enhancement

therapy; the overall intervention included information from a presentation delivered by a guest dietitian.

Weber and colleagues (2006) reported that post-treatment results indicated significant improvement for all of the participants when compared to pre-treatment assessments. Three weeks prior to the group's initial session, six of the seven participating women were classified as having severe or extremely severe depression, according to the researchers use of a depression, anxiety, and stress scale. However, post-group results showed significant improvement in the women's classification of symptoms with one woman classified as mild, one as moderate, and the remaining five as normal 3 weeks after the group concluded. Similar findings were reported when assessing for the risk factors associated with eating disorders. By using a standardized eating disorder inventory, Weber and associates identified a significant reduction in the number of scores within or above the clinical range on the eating disorder risk scale as well as a reduction in the number of scores within or above the clinical range on the other psychological profiles. Participants also reported implementing newly learned coping skills, discontinuing the use of anti-depressants, being less rigid with food, and being more kind to and accepting of their bodies at the time of the three week follow up assessment. Although these findings provide some evidence that a narrative therapy group counseling intervention provides adult female participants with significant improvement in coping skills and assists them in reducing or eliminating symptoms of depression and behaviors associated with and risk factors for eating disorders, the absence of a control group and the size of the sample limits the generalization of the results to others. Furthermore, the results may vary with a more culturally or ethnically diverse group.

Narrative therapy with adolescent girls. In response to a request from an Iowa County Juvenile Court to design a treatment program for adolescent female offenders and as a means to evaluate the effectiveness of narrative therapy with adolescents, Kelly and colleagues (2002) created a summer intervention program that implemented the use of narrative therapy. The study was guided by three questions: 1.What are the experiences of adolescent girls who break the law? 2. What is the relationship between the participants' lived experiences and the stories they develop about themselves? 3. Is a narrative therapy approach effective in helping this population to identify and utilize the strengths and resiliencies that they possess in order to help them to better cope with the challenges in their lives? The participants consisted of an ethnically diverse group of eight adolescent girls aged 13 to 17 years old, who had been charged with offenses such as assault and theft. All of the 10 court-referred girls were accepted into the program; however, participation in the group was not mandatory in order to receive treatment from the agency. Eight of the girls consented to participate both in the group and in the study, and those who chose not to participate in the group were not penalized for doing so. The group met for 3 hours a day, 5 days a week, for 8 weeks. Each session usually began with an hour-long group discussion followed by a creative activity of the girls' choosing. Kelley and her associates (2002) utilized creative activities as a means to facilitate self-reflection and self-expression. The group experience also included other special activities and field trips from time to time.

Through the use of both qualitative and quantitative analysis of the data, Kelley and associates (2002) found that the use of a narrative group approach was effective in facilitating the participants to examine their lives and re-author their stories. Furthermore, their results indicated that, through the pairing of narrative interventions and creative

activities, the girls were more willing to open up and share personal information and they were more able to examine their lives and the stories they told themselves. The results also provided them with insights into the challenges that they experience, such as their feelings of being shunned by society. As a result, the participants demonstrated a sense of hardness or toughness as a means of coping in a privileged world.

Some of the common problem themes that were evident in the transcript analysis were violence, anger, loss, premature adulthood with little preparation, chronic transition, and a lack of trust. However, for every problem theme that arose in the group, a solution or coping theme emerged and was highlighted during the group. Two findings that Kelley et al. (2002) discussed as important, yet unexpected, were that the members of this group had high rates of self-esteem and a sense of internal locus of control at the start and finish of the intervention. The researchers concluded that, despite having higher than average rates of mental health problems and having experienced many challenges in their lives, the girls' beliefs that they were in control and that they felt okay about themselves were important coping strategies that they had developed (Kelly et al., 2002). Once again, the sample in this study is too small to make definitive claims; the lack of a control group and of diversity among the participants further limits the study.

Summary. Narrative therapy uses a series of interventions to help clients understand the origins of their challenges, the ways in which they participate in the subjugation of their own lives, the reasons why they have developed the self-defeating and self-destructive behaviors that they have, and the way to re-author new narratives that are more consistent with their lived experiences. Throughout their work, clients learn how to incorporate their new narratives and their new personal and social awareness into their lives, allowing them to

be better able to cope with life experiences and implement new behaviors (Carr, 1998; Corey, 2009; White & Epston 1990). Although the studies reviewed in this section are limited, it appears that narrative therapy is effective at helping clients to gain new societal and personal insights, to develop self-awareness and self-expression, to learn new coping skills, and to feel empowered through re-authoring the stories by which they live (Carr, 1998; Corey, 2012; Kelly et al., 2002; Leahy & Harrigan, 2006; Weber et al., 2006; White & Epston, 1990).

Art Therapy

Malchiodi (2007) explained that art therapy is the merging of two distinct disciplines, art and psychology, to form one therapeutic technique. This modality takes aspects from the visual arts and the creative process and applies them to personality development, to mental and behavioral health, and to overall personal well-being. Art therapy, or the expressive arts, includes the use of creative art, dance, music, play, and drama to facilitate personal exploration for therapeutic gains (Corey, 2012; Heenan, 2006; Malchiodi, 2007).

Theory. Art has been found to be a natural form of self-expression and self-exploration (Frisch et al., 2006; Huss et al., 2012) and, when combined with a therapeutic modality such as a counseling group, individual therapy, or family therapy, it has been found to be effective in helping people cope with a wide variety of challenges such as, addiction, trauma, chronic and terminal illness, difficulties within a family, war veterans, and people with disabilities (Golub, 1985; Hanes, 2007; Malchiodi, 2012; Matto, 2008; Meshcheryakova, 2012; Tarzaska, 2012) .

The field of art therapy consists of two common definitions or approaches; one is typically known as art as therapy, which is based on the assumption that the process of creating art is therapeutic, healing, and growth producing in and of itself (Hartz &Thick,

2012; Malchiodi, 2007). The other is known as art psychotherapy, which assumes that the created products (drawings, paintings, dances, sculptures, etc.) are a form of expressing emotions, conflicts, and issues and through exploring and interpreting the meaning of the product therapeutic gains are made (Hartz &Thick, 2012; Malchiodi, 2007). In this approach, art therapists work with clients to help them assign their own personal meaning to their work. Art therapists do not provide interpretations for clients because the production of art is a very personal experience that results from individual experiences, cultural influences, and personal perspectives. The process of clients giving their own work meaning is a very important part of the therapeutic process. Despite the two approaches being significantly different in how they interpret how change occurs, modern art therapists usually integrate both approaches to some extent (Malchiodi, 2007).

Malchiodi (2007) discussed the healing process that occurs in art therapy: the creative process and the art products come from within clients as a result of their life experiences and emotions; art provides a way of expressing what the mind is storing in a nonverbal way. When words cannot adequately express what people are experiencing, art gives them an alternative form of expression. People find that they do not have the ability to express themselves verbally for multiple reasons; some do not have the language necessary to do so, while others find that verbalizing their experience is too painful, shameful, or risky (Frisch et al., 2006; Huss et al., 2012; Malchiodi, 2007). Words can also hinder their ability to express themselves because words give people a way to avoid, hide, or disguise their true experiences and feelings. Because there are no rules to creating art, unlike what is true about the spoken and written word, people can use art to express multiple and even conflicting elements at one time. According to Malchiodi (2007), the ability to express conflicting and

confusing ideas in a single product allows for people to begin to integrate their experiences in a more functional way.

Furthermore, the act of creating art is a multi-sensory experience involving vision, touch, movement, and sound. The sensory experience that is a part of art therapy allows people to tap into their bodies and to gain a new awareness of their inner experience. Insight into how an experience has manifested in the body can provide clients with a greater understanding of themselves. Malchiodi (2007) reviewed the research and concluded that engagement in the production of art is an effective form of emotional purging and helps to alleviate stress, anxiety, and depression through the natural release of serotonin; it also induces a meditation-like state that allows people to find inner peace and calm.

Research. Art therapy has been found to be an effective assessment tool and intervention for people of all ages in many different countries worldwide (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006; Huss et al., 2012). Research studies have found that, when producing art is used as an intervention, people are able to reduce symptoms of depression and anxiety, develop new coping skills, and improve their sense of self and well-being (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006).

Art therapy for treating eating disorders. Frisch and associates (2006) explored the use of creative arts therapies in residential treatment centers for people who have an eating disorder. They identified 22 treatment centers in North America that implement the use of at least one form of creative arts therapies to aid clients in their recovery. The treatment philosophy of these centers incorporated art therapy, as an alternative and holistic form of therapy, with traditional, empirically researched approaches, such as cognitive behavioral, family-systems, and interpersonal therapy. Information gathered from the 19 participating

treatment centers found that art-based therapies provided clients with a non-threatening alternative to self-exploration, self-expression, and self-discovery; the number of respondents in this study was not mentioned by the authors. Art therapy appeared to be most effective with clients who experienced difficulty with traditional forms of talk-oriented therapies. The art activities, facilitated by certified art therapists, allowed clients to work through challenging issues, including low self-esteem, poor body image, patterns of isolation, and depression, by developing a greater awareness of their feelings and of how to integrate them through the use of positive coping skills.

Frisch and her colleagues (2006) also reviewed the literature addressing the use of creative arts therapies in the treatment of eating disorders; they found 30 studies or papers and identified three major sub-specialties of creative arts therapies that were considered to be common approaches in the treatment of this population: music therapy, dance/movement therapy, and art therapy. Music therapy is an approach that uses music as a tool to facilitate self-discovery. For example, therapists can guide clients to listen to music and analyze lyrics to facilitate gaining greater self-understanding and to apply the newly gained insight to their lives. Music is also used as a means to facilitate relaxation; for example, music can be played in the background during meditation and breathing exercises or during mealtimes to help ease anxiety. Dance/movement therapy aims to facilitate change on a cognitive, social, emotional, and physical level through creating positive change in the body. Dance/movement therapists believe that the mind and body are interconnected and any change in the body results in change in the mind. Frisch and associates (2006) found that the use of dance/movement therapy was usually coupled with a traditional form of psychotherapy; they employed techniques such as mirroring each other's movements,

creating drawings that represent the movement exercise, videotaping their bodies and movements following self-critiquing and reflection, and creating an outline of their body based on how they perceived themselves in the mirror and then comparing it with an actual tracing of their body.

According to Frisch et al. (2006) art therapy was the most commonly used form of creative arts therapies in the treatment of eating disorders. The use of drawing, painting, sculpting, drama, and role-playing were implemented as tools to facilitate change. Although the specific techniques used varied from study to study or paper to paper, two themes became apparent: the use of symbolism as a tool to gain new insight and an emphasis on the importance of art therapy as an alternative form of self-expression and self-exploration (Frisch et al., 2006).

Art therapy for promoting positive mental health. Heenan (2006) collaborated with Support, Training, Education, Employment, and Research (STEER), a community-based mental health organization in Northern Ireland, to evaluate the effects that art-based therapy has on the well-being of a person living with mental illness. People receiving services through STEER had a history of mental health problems, were referred by their primary care physicians or psychiatrists, and received services free of charge. While in this supportive recovery program, clients were provided with the option of participating in five different modules, one of which was art as therapy. Each module met for 10 hours a week for 10 weeks. Participants in the study consisted of a randomized sample of 40 previous participants in the art as therapy module who were invited to participate in either a focus group or in an individual interview. A total of 20 interviews and two, 10-member focus groups were conducted. Participants were between the ages of 18 and 55 years old and 12 of

the interviewees were female and 13 of the focus group participants were female. Responses from the participants were analyzed and three themes emerged: self-esteem, empowerment, and a safe space (Heenan, 2006).

Participants reported a significant increase in their self-esteem and self-confidence as a result of engaging in the artistic process and through the gaining of new skills and knowledge (Heenan, 2006). Some reported that, before starting the art classes, they felt like they were at the end of their tether, sick of suffering in silence, and they had nothing to lose. After completing the 10-week program, many reported feeling less fragile and vulnerable, more able to buffer the risks in life, and confident enough to deal with their underlining mental health issues. Some also reported learning more positive social behaviors, how to relax, and how to accept their bodies as they were. Another common theme that emerged in the results was a greater sense of empowerment in the participants. The clients claimed that this empowerment came as a result of being treated as the experts in their mental health, and not as patients, and from being in an environment that focused on what they could achieve, rather than on their problems. Participants reported that the artistic process was liberating and therapeutic, the opportunities to interact with others (in a group) gave them a greater sense of freedom, and that overall the course gave them a greater sense of independence. Ultimately, due to this newly gained sense of empowerment, freedom, and independence, many participants reported getting involved in other activities in the community following the completion of this program.

The third common theme that Heenan (2006) identified in the results was that the program provided participants with a safe space. Classes were described as being relaxing and cathartic, and as providing a release from stress and anxiety. Participants also reported

that the program did not require that they interact with one another; they were welcome to work individually or to collaborate with their peers; this created a greater sense of safety. Heenan (2006) explained that the need for safety may have been heightened, due to the environment of hostility and distrust in Northern Ireland at the time, given the wake of generations of civil disturbance. People reported that they often found themselves unable to discuss their pain and personal suffering. Prior to entering the program, participants reported feeling vulnerable, uneasy, and living with anxiety and distress as a part of their everyday existence, and having to suffer in silence because of their inability to talk to others and because of the social stigma regarding mental illness. Participants stated that they felt safe receiving services from STEER because they were not part of the statutory mental health services, which were considered by many to be too risky and suspicious. According to the study, this sense of safety allowed participants to initiate their recovery and to explore their personal issues for the first time (Heenan, 2006).

A significant limitation to this study is that the art as therapy module was not led by a certified art therapist; rather, STEER employed an art teacher to lead the group. The goal of the intervention was to see if the process of creating art and gaining new artistic skills would be enough to improve the well-being of the participants. However, Heenan (2006) speculated that, had this group been facilitated by a certified art therapist, the results may have been even more profound. Another limitation of the current study is that the members of the participating group, although diverse in age and gender, were not diverse in terms of their cultural or ethnic backgrounds; this limits its generalizability to more diverse populations. Being that the participants were all adults, these results may also not be generalizable to children or adolescents. However, given that the purpose was for

participants to feel safe enough to relax, learn new art skills, and enjoy the artistic process, in an effort to promote positive mental health, it is reasonable to suggest that similar findings would result with a wide variety of groups of various demographics, given the proper setting.

Art therapy as an intervention to increase self-esteem. To assess for differing outcomes between the uses of art psychotherapy or art as therapy as a means of impacting a person's self-esteem, Hartz and Thick (2012) implemented each of these interventions with two different groups of adolescent girls who were currently residing in the juvenile corrections department. The participants of these two groups consisted of 27, 13 to 18 year olds from Caucasian, African American, and Hispanic backgrounds. Each girl was in the residential correctional facility as a result of being charged with a felony-level crime, and most were behind academically, from a disadvantaged socioeconomic home, and had a history of abuse, gang involvement, substance abuse, trauma, or abandonment. The residential center already implemented group counseling sessions for each of its residents five days a week and family counseling once a month (Hartz & Thick, 2012).

Hartz and Thick (2012) randomly assigned 12 girls to be a part of the art psychotherapy intervention and 15 to be a part of the art as therapy intervention. The groups met for 10, 1.5 hour-long sessions over the course of 12 weeks. Each group received the same projects and identical materials; the only difference between the two groups was the way the introduction, warm-ups, and closures were designed. The art psychotherapy group contained a psychoeducational component, which encouraged abstraction, symbolism, and verbalization, and these participants were encouraged to focus on self-awareness and insight, whereas the art as therapy group emphasized design potential, techniques, the creative problem-solving process, artistic experimentation, and accomplishment.

Post-treatment survey results found no differences between the effectiveness of the two groups; 75% of the participants from both the art psychotherapy group and the art as therapy group believed that the intervention was helpful in furthering the development of their self-esteem, mastery, social connection, and self-approval (Hartz & Thick, 2012). Participants also reported feeling better able to express their feelings, knowing how to better cope with and relieve stress, and knowing how to productively release anger as a result of both of the art interventions. Although the results demonstrated that the participants perceived each group to be equally effective, differences were identified in two of the self-esteem domains, social acceptance and close friendship. Those in the art as therapy group showed greater improvements in social acceptance, which Hartz and Thick (2012) explained could have been a result of the general social environment provided by the group, the sharing of materials and techniques, and through the observation of each other's work. Groups like this one can establish a sense of belonging for a person and establish a sense of cohesion in a group that could later result in a sense of safety and willingness for participants to self-disclose and establish supportive relationships. The art psychotherapy group showed improvements in the close friendship domain; these participants improved in their ability to form personal connections (i.e., trust, closeness, and comfort in self-disclosure). Hartz and Thick (2012) proposed that this was a result of the psychoeducational component and the emotionally safe environment that the intervention provided, coupled with the validation of positive social norms and the encouragement of self-disclosure. The ability to self-disclose has been found to be a key in the formation of friendships, which are critical in the development of self-esteem; self-disclosure also correlated with stronger participant relationships with treatment providers.

Possible limitations to this study are that the sample size is relatively small and that the girls were participating in this group while remaining involved in other forms of treatment at the center. Because the girls were simultaneously participating in multiple treatment interventions, the reasons for improvements in self-esteem are difficult to isolate; however, contrasting two different forms of art therapy made it possible for Hartz and Thick (2012) to tease out the contributions that art therapy had on the participants.

Summary. Art therapy is the product of the merging of art and psychotherapy to form one therapeutic technique (Malchiodi, 2007). Although commonly combined in the current practice of art therapy, two specific types have been identified: art as therapy and art psychotherapy itself (Hartz &Thick, 2012; Malchiodi, 2007). Art therapy states that the creative product comes from within clients as result of their lived experiences and that it is through experiencing the expressive arts, including the use of creative art, dance, music, play, and drama, that clients are able to express emotions and thoughts that they may not otherwise be able to do verbally (Corey, 2012; Hartz &Thick, 2012; Heenan, 2006; Malchiodi, 2007). The research on the effectiveness of art therapy has consistently shown that clients report improved self-expression, coping skills, and self-esteem, as well as a reduction in symptoms of anxiety, depression, and other mental health issues (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006).

Psychoeducation

Psychoeducation is the presentation and discussion of factual information in a therapeutic setting with the intention of participants gaining knowledge, insight, and awareness (Corey, 2012). In a psychotherapeutic setting, psychoeducation is commonly used to impart new information, provide an opportunity to share common experiences, teach

problem solving skills, provide support, and help participants learn how to create their own support network. Psychoeducation is commonly structured to help people develop new skills and behaviors, understand certain themes, process a personal trauma or crisis, and/or to progress through a difficult life transition. According to Corey (2012), psychoeducation and psychoeducational groups are suitable for people across the lifespan and can be designed to accommodate any developmental phase.

To evaluate the effects that media-related psychoeducation had on women's internalized body ideals, Yamamiya, Cash, Melnyk, Posavac, and Posavac (2005) designed four research conditions: (a) one group received control images (images of automobiles) and control information (information about parenting and child development), (b) a second group received media images (images of fashion models) and the same control information, (c) a third group received media images and psychoeducation regarding media-literacy, and (d) a fourth group received media images, dissonance-induction, then media images again. Participants consisted of 123 Caucasian, female college students ranging in age from 18 to 29 years old who were randomly assigned to one of the four research conditions. Only Caucasian women were selected because the media images were of Caucasian female models. Prior to participating, the women were asked to fill out various forms and provide information regarding their demographics; the packet included an assessment survey designed to evaluate their sociocultural attitude towards appearance, specifically regarding the internalization of body types portrayed in the media. The women were then classified as having high media-ideal internalization or low media-ideal internalization.

The women attended the research sessions in small groups of no more than five and were informed by a female experimenter that they were to be participating in product

research for new educational programs and select products. Each group was then provided with the psychoeducation or the control information and given 5 minutes either to compile a list of the facts that were reported or provide a persuasive argument, depending on the condition to which they were assigned. Following the completion of the written exercise, the participants were introduced to a "second consumer research study," where they were given mock surveys to be completed based on their options of the products displayed in the images shown to them, images of automobiles or fashion models. The third and final part of the study consisted of asking the participants to complete a body image scale that measured their current dissatisfaction-satisfaction with their physical appearance (Yamamiya et al., 2005).

Yamamiya and associates (2005) reported that, after 5 minutes of exposure to fashion models, participants who were classified as having high media-ideal internalization had a more negative body image state than those who were exposed to the control images. However, these negative effects were significantly mitigated by the media-literacy psychoeducation activity. These findings were not consistent for women who were classified as low media-ideal internalization; in fact, none of the research conditions had an effect on these women. One limitation that prevents generalizing the results of this study to the general ethnically diverse population is that all of the participants were female, Caucasian, and college students from a single university. Another limitation that Yamamiya and colleagues (2005) discussed is that a short intervention, such as this, is not likely to have lasting effects, especially when exposure to the media occurs multiple times a day. Nonetheless, the results suggest that media-literacy psychoeducation may significantly reduce a negative body image, especially for those who seem to be most vulnerable to internalizing the media-ideal.

Group Therapy

Group therapy has become a common therapeutic modality both in the United States and internationally due to its ability to reach several participants at one time in a cost effective way (Corey, 2012). Groups can be formed for educational or therapeutic purposes with preventive and/or corrective intentions and are usually focused on areas such as educational, career, social, or personal. One of the unique characteristics of group therapy is that it allows group members to develop interpersonal communication skills and new beliefs and behaviors while expressing and processing through thoughts and feelings. Having a group setting allows participants to gain social support while they learn and practice new skills and obtain new insights and awareness. The safe environment of the group allows participants to practice new behaviors without the potential consequences of the real world until they are ready to implement them in their outside life. Counseling groups are usually growth oriented and encourage the members to determine the goals of the group. While implementing the use of a selected therapeutic model, or multiple models, the counselor uses techniques and structured exercises to engage the participants, encourage interaction and communication, help them learn from one another and establish personal goals, and encourage them to turn new insights into actions that can be implemented in their everyday lives (Corey, 2012).

To determine the effectiveness of group counseling, Burlingame, MacKenzie, and Strauss (2004) reviewed 107 studies and 14 meta-analyses that implemented the use of group counseling as treatment for various disorders (mood, eating, substance abuse, personality, and psychotic) and with several different populations (elders, domestic abuse, sexual abuse, and medically ill). Their results indicated that group counseling is just as effective as

individual counseling. Specifically, Burlingame and fellow researchers concluded that group therapy was an effective modality for the treatment of bulimia nervosa with greater post-treatment results associated with more therapeutic hours. On average 9 to 15 sessions were needed in order for therapeutic results to be sustained (Burlingame et al., 2004).

According to Corey's (2012) review of the literature, group counseling for adolescents helps to reduce the stigma associated with therapy, reduces resistance to participate, and allows participants to recognize that they are not alone in their struggles. In an effective counseling group, adolescents are able to safely express their feelings, explore conflicts and self-doubts, and examine their values and behaviors. As in any counseling group, teens work with group mates to brainstorm and implement personal changes that result in life experiences that are more consistent with their desired lifestyle. Effective group leaders of counseling groups for adolescents are instrumental in encouraging and facilitating peer communication, modeling appropriate behaviors, and ensuring a safe space for the participants to test their limits (Corey, 2012).

Integration of Theory, Research, and Practice

In this chapter, narrative therapy was introduced as a therapeutic model that has been found to be successful in facilitating self-expression, helping clients gain new cultural insight and self-awareness, and in empowering clients to learn new coping skills and to re-author their stories, such that they are more congruent with their lived experience (Carr, 1998; Corey, 2009; Kelly et al., 2002; Leahy & Harrigan, 2006; Weber, et al., 2006; White & Epston, 1990). The proposed intervention implements narrative therapy as an effective theoretical approach for treating adolescent girls struggling with low body-esteem, given its ability to help clients gain understanding of the context in which their struggles have

developed, increase self-acceptance, identify personal strengths and abilities, and cultivate new behaviors (Kelley et al., 2002).

Art therapy was introduced as an effective assessment and treatment intervention for improving self-expression, enhancing coping skills, and building self-esteem, as well as for reducing symptoms of anxiety, depression, and other mental health challenges (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006; Malchiodi, 2007). Therefore, the therapeutic use of art therapy exercises is integrated into the proposed intervention as an effective means of increasing body-esteem in adolescent girls. The use of the creative arts with this population aims to provide them with alternative and nonthreatening ways to open up and self-disclose, while also allowing them to remain in control and to feel less vulnerable, to learn new ways to self-soothe, and to gain new self-awareness (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006). Psychoeducation was presented as an optimal means of providing information to clients in a psychotherapeutic setting and to facilitate the development of new behaviors (Corey, 2012; Yamamiya et al., 2005). In this paper, psychoeducation is proposed as a means to provide information to adolescent girls to assist them to be wise consumers of the media and, specifically, to gain self-awareness in regards to how the media may impact and influence them, to enhance their socio-cultural understanding, and to develop skills to critically analyze the media's portrayal of the idealized female body. Furthermore and as important, the proposed intervention includes psychoeducation about the value of health and wellness that aims to inform and empower participants to modify their narratives, make new choices, and change their behaviors to be more consistent with their desired healthier lifestyle. It is not the purpose of this paper to detail a summary of the latest research on what is considered proper nutrition, optimal physical exercise, and other habits that promote

wellness; such information is important and group leaders are advised to draw from the following resources: the United States Department of Agriculture Center for Nutrition Policy and Promotion (2012), the Center for Disease Control and Prevention (2012), the American Academy of Pediatrics (n.d.), and Let's Move (n.d.). Counselors leading this group are also encouraged to bring in a few experts, such as a pediatrician, nutritionist, and/or physical fitness expert to talk about the value of moderate exercise, good nutrition, adequate sleep, and other healthy life habits.

This chapter also documented that group therapy is an effective modality for conducting psychotherapy with adolescents (Corey, 2012). Implementing the proposed intervention for adolescent girls through the modality of group counseling is a time and cost effective way for several girls to obtain help in rebuilding their body-esteem. This group is designed to provide participants with an opportunity to build positive peer connections, explore their struggles; re-author their narratives; learn about health and wellness and establish healthy life habits; reduce feelings of isolation, depression, and anxiety; and to obtain self-understanding and self- acceptance.

Therefore, in Chapter III, a narrative therapy counseling group for girls with low body-esteem is proposed. This group includes art therapy experiences to enhance participants' self-exploration and self-expression; psychoeducation is utilized to present information and help participants integrate their knowledge into new beliefs and behaviors. The overarching purpose of this group is to support adolescent girls to be healthy by increasing their body-esteem, overall self-confidence, and healthy life habits. The proposed group aims to facilitate the re-authoring of the adolescents' narratives regarding their body

image, to reduce the use of unhealthy weight control behaviors among the group participants, and to empower the girls with the knowledge necessary for them to sustain a healthy life.

Chapter III

Application

The standard of physical beauty for females in the United States has become increasingly more impossible to achieve, as the ideal body type becomes increasingly thinner over time (Duba et al., 2010). Living in an environment where the media is inundated with models who are thinner than 98% of U.S. women (NEDA, 2005) and where 30% of actresses on television are underweight (Kaiser Family Foundation, 2004), combined with the societal pressure to be thin in order to obtain familial and social approval and status (Duba, et al., 2010; Kluck, 2010; Neumark-Sztainer et al., 2010), adolescent girls are experiencing serious psychological, biological, and social consequences. They are acquiring a fear of becoming fat as early as 10 years old (Collins, 1991), and they are developing low body-esteem and high rates of body dissatisfaction in preadolescence (Harrison & Hefner, 2006). Over half of girls report implementing the use of a variety of unhealthy and dangerous weight control behaviors to aid them in their pursuit of physical perfection (CDC, 2006; Kluck, 2010; NEDA, 2005; Neumark-Sztainer et al., 2010). In addition, adolescent girls are developing low self-esteem, depression, anxiety, suicidal ideations and behaviors, and partial to full-symptom eating disorders as a result of continuously striving to obtain their ideal body (Brausch & Muehlenkamp, 2007; Cromley et al., 2012; Green et al., 2009; Kim et al., 2011; Shisslak et al., 1994; Stice et al., 2001).

Chapter II introduced narrative therapy (Carr, 1998; Corey, 2009; Etchison & Kelist, 2000; White and Epston, 1990) and art therapy (Frisch et al., 2006; Huss, Nuttman-Shwartze & Altman, 2012; Malchiodi, 2007) and reviewed the research that confirmed the effectiveness of these approaches with international populations (Frisch et al, 2006; Hartz &

Thick, 2012; Heenan, 2006 Leahy & Harrigan, 2006; Weber et al., 2006). This review concluded that the use of both narrative therapy and art therapy are effective therapeutic models to be used to facilitate change across the lifespan in a therapeutic setting. Psychoeducation was then introduced as a way for factual information to be introduced and discussed in a therapeutic setting (Corey, 2012) and as an effective way to educate adolescent girls on topics such as proper nutrition and wellness and how to critically analyze the media (Yamamiya et al., 2005). Finally, the modality of group counseling was introduced as an appropriate form of counseling for adolescent girls due to its ability to reach multiple participants at one time, establish a sense of companionship, reduce feelings of isolation, and allow participants to brainstorm and practice new behaviors with one another (Corey, 2012). Chapter III proposes a narrative, creative arts, preventative counseling group for adolescent girls who may be struggling with low body-esteem as a result of their social environments.

Group Purpose and Goals

Through the proposed unique integration of narrative group therapy, creative art exercises, and psychoeducation, participants have an opportunity for self- and cultural-exploration, to gain knowledge that may be beneficial to them for life, and to develop new coping skills and behaviors in a safe and supportive environment. The purpose of the proposed group is to assist girls in re-authoring their self-narratives such that positive body-esteem is cultivated, the use of unhealthy weight control behaviors is reduced, and the girls are empowered with the knowledge necessary for them to sustain a healthy life. Additional goals include helping the girls learn to: (a) use healthy coping skills, (b) recognize the environmental influences that shape their beliefs about their bodies and their self-worth, (c) understand that body-esteem is a society-wide problem that affects people other than

themselves, and (d) grasp the importance of health and of adopting healthy behaviors that support their physical and mental well-being. Therefore, to summarize, the overarching purpose of this group is to support adolescent girls to be healthy by increasing their body-esteem, overall self-confidence, and healthy life habits (Hartz & Thick, 2012; Heenan, 2006; Kelley et al., 2002; Leahy & Harrigan, 2006; Weber et al., 2006).

Group Guidelines and Informed Consent

To empower the group members with the knowledge of their basic rights and responsibilities in regard to their participation in the group, the therapist provides each selected member with a detailed consent for treatment form (see Appendix A) for their review and signature (Corey, 2012). This form explains the potential risks and benefits of entering psychotherapy, confidentiality and its limits, termination, the cancellation policy, and the fees associated with attending the group. In addition, in order to create and maintain a safe therapeutic environment for the group participants, each girl is required to agree to sign a group contract that details member expectations (see Appendix B). The group contract spells out rules around topics such as attendance, participation, use of illicit drugs and/or alcohol, violence, and potential risks to participating in group counseling.

Group Structure

The 12-week, narrative therapy group described in this paper is for approximately eight adolescent girls with low body-esteem. It is designed to meet once a week for 90 minutes with an additional 50 minute pre- and post-group individual session; however, the structure of the group can be adapted to other formats. The group sessions are held once a week at a local public facility that is able to provide a private meeting space, like a library, school, or community center. Each session is rooted in narrative therapy and incorporates

creative art exercises to facilitate exploration and skill building or psychoeducation to provide information on health and wellness. This group is a closed group; that is, no new members are admitted once the group has commenced. Providing a closed group provides a sense of privacy, confidentiality, predictability, stability, and continuity for the participants (Corey, 2012).

Group Members: Selection Process and Criteria

To advertise the group, informative flyers can be posted within the community at places like libraries, coffee shops, community bulletin boards, and internet forums. School faculty, administration, and counselors, along with other mental health professionals in the community, should be advised of this upcoming resource. Postings can be made in school newspapers and newsletters and with local parenting groups and sports organizations. Any girl between the age of 14 and 18 years old who has been reported, or who self-reports, as having low body-esteem and who is willing to commit to the therapeutic process, is invited to be a member of the group.

Girls who are interested in participating in this group are pre-screened through a two-step process. They are first pre-screened during a brief phone conversation: the group therapist inquires about the teens' demographics (age, name, phone number, etc.), reasons for being interested in the group, and any mental health diagnoses they may already have. An individual, in person, pre-group screening meeting with the group therapist is then scheduled for the girls who meet the required selection criteria. During each individual session, the therapist provides enough information to the girls in order for them to make an informed consent about whether or not they wish to make a commitment to the group. This information includes: the details of the group, the risks and benefits of entering counseling,

and confidentiality and the limits to confidentiality (Corey, 2012; Corey, Corey, Callanan, & Russell, 2004). The consent for treatment and the group contract are introduced and discussed (Appendices A and B). Once the consent for treatment and the group contract are reviewed, each participant has an opportunity to discuss her goals, expectations, questions, and worries with the group therapist.

The requirements for obtaining consent from parents or legal guardians when minors choose to enter into psychotherapy vary from state to state. For example, under California Family Code 6924, minors 12 years of age or older are not required to obtain parental consent to participate in psychotherapy when both of the following are met: First, the providing professional must deem the minor to be mature enough intellectually to participant in treatment, and, second, (a) the minor is in danger of inflicting physical or mental harm to self or others if he or she does not receive treatment, or (b) the minor is the alleged victim of incest or child abuse (Legislative Council of California, n.d.). Therefore, therapists should proceed with obtaining consent from a parent or legal guardian according to their state requirements. For states that do not require consent from a parent or legal guardian, group therapists should encourage members to review all of the provided information with their parent(s) or legal guardian(s) and obtain at least one parental or legal guardian's signature on the consent for treatment form. Both forms are to be signed by the group members, brought to the first group session, and collected by the group therapist.

Girls who are not an appropriate fit for this group are those who have a serious behavioral, mood, or personality disorder such as severe depression, unmanaged bi-polar disorder, or oppositional defiant disorder. Other reasons for excluding potential participants include if they have attempted suicide in the last 3 months, have a serious drug and/or

alcohol problem, or have experienced serious trauma. Girls struggling with such significant issues would not be an appropriate fit for the group due to the potential for serious emotional instability. Girls not admitted into the group for any of the above reasons would be provided with referrals to more appropriate forms of treatment, such as individual or family counseling, substance abuse treatment centers, psychiatrists, or more suitable counseling groups. If more than eight girls fit the criteria for this group, a second or third group can be administered at the therapist's discretion.

Overview, Theoretical Orientation, and Sessions

The proposed group is rooted in narrative therapy as a means of re-authoring the stories that adolescent girls tell themselves about their bodies (Carr, 1998; Corey, 2009; Kelley, et al.; White & Epston, 1990). As previously stated, the group is designed to help girls to challenge and change any beliefs that they have internalized about the ideal standard of physical beauty (Collins, 1991; Harrison & Hefner, 2006); to discontinue or prevent self-destructive behaviors, like the use of unhealthy weight control methods (Field et al., 2005; Kluck, 2010; Neumark-Sztainer et al., 2010); and to eliminate symptoms of mental health disorders, such as depression, anxiety, and eating disorders (Cromley et al., 2012; Green et al., 2009). A therapist or co-therapists skilled in working in groups with teenage girls and in narrative therapy, as well as in therapeutic use of the creative arts, implements the eight interventions that define narrative therapy throughout the 12 group sessions. To further facilitate self-exploration and to provide the group participants with an alternative and less threatening form of self-expression, creative art exercises are included in most sessions (Frisch et al., 2006; Huss et al., 2012; Malchiodi, 2007). During those sessions, the girls are provided with a variety of art materials, including markers, pencils, construction paper,

cardboard, tissue paper, glue, paint, and clay; the therapist guides the girls into the open-ended activity with instructions to initiate each specific art exercise (some examples are provided later and in Appendix C). After the time for engagement in the creative art activities has been completed, the therapist facilitates the girls' sharing and work together using narrative therapy.

The group leader integrates psychoeducation into the group when appropriate and as planned; therefore, factual information about physical health (daily exercise, proper nutrition, and good sleep hygiene) and psycho-emotional health (positive body esteem, internal locus of control, strong social support, etc.) is introduced and discussed in a therapeutic setting (Corey, 2012). The girls are also assisted to become more critical of the messages given to them by the media and society at large about their physical appearance, and they are given skills to critically analyze the media. The aim of this integrative approach is to reduce the negative effects of the media and of society on the participants' internalized body- and self-ideal (Corey, 2012; Harrison & Hefner, 2006; Yamamiya et al., 2005). Experts in the community are brought into the group occasionally to present this information to the participants; for example, a local pediatrician with an expertise in sports medicine or in integrative medicine may be a helpful presenter. The group therapist may also bring psychoeducational materials to the group, when appropriate.

The first session is dedicated to building rapport amongst the group participants and the group therapist; solidifying the group's structure and goals; discussing any questions, concerns, fears, and hopes; and naming the problem that each girl identifies as a struggle (Corey et al., 2004). During each session, the girls and the therapist are seated at a table in a circular fashion in order to create an inclusive, open discussion environment. After

reviewing the goals, rules, and structure of the group, each girl is asked to introduce herself by providing the group with her name, age, reason for joining the group, and one unique fact about her. Following this ice-breaker activity, the group therapist facilitates a brief open conversation regarding how each girl defines health, beauty, and wellness.

Then, the group therapist prompts the members to use whatever art materials they wish to create a poster that names and/or illustrates their problem or challenge (in terms of maintaining body-esteem). Participants are asked to share their finished products with the group and explain what they believe is their problem or challenge. During this time the therapist notes the internalized messages the girls have adopted. The group therapist then points out the common theme(s) amongst the group members, highlighting that they share a similar problem, reviews the internalized messages the girls use to describe the problem, and then facilitates an open conversation to help them begin to identify what is outside of them that may be feeding the problem. The posters that each girl created are collected and kept by the group therapist. A homework assignment for the girls is to pay attention to all of the messages that they receive from their environment regarding the ideal body type, the ways of achieving it, who supports the desires to obtain this body type, and who benefits, profits, and/or agrees with girls' pursuit for physical perfection (Duba et al., 2010) and make a record of what they notice in their journal or notebook.

Most of the remaining sessions are structured in a similar way to this first one. 1. The group therapist welcomes the girls to the session and the agenda is presented. 2. The homework assignment (given the week before) is discussed. 3. The week's intervention or presentation is introduced, usually with a matching creative art exercise. 4. The girls' art products are shared and facilitative questions are asked by the group therapist. 5. Narrative

therapy is used to assist the girls to: (a) externalize the problem they are experiencing; (b) evaluate the effects it has on their lives; (c) gain an understanding of the problem in a social, political, and cultural context; (d) determine the relationship that they want to have with the problem moving forward; and (e) re-author a new narrative that is less-problem-saturated and more consistent with their lived experiences. 6. Any homework for the following week is introduced and assigned. 7. Any remaining questions or thoughts are encouraged before the session ends and all products created during the session are collected and kept by the group therapist. Descriptive outlines for the first four sessions and the last four sessions of the proposed narrative therapy group are in Appendix C. The group therapist follows the provided format for the four remaining sessions.

Group Termination and Follow-up

Two of the concluding narrative therapy interventions that are integrated into this group are *outsider witness* and *incorporation* (Carr, 1998; Corey, 2009; White & Epston, 1990). These two interventions are crucial for the termination process of this group and begin in session 10. The group therapist, skilled in narrative therapy, introduces the concept of outsider witness and collaborates with the girls to identify the support they need to move forward (beyond the group). The group therapist and members assist the girls to consider who could be their outsider witness and with whom they can share their new narrative. This person is someone whom they trust and with whom they can connect, outside of the group, who is apt to provide the support and encouragement that they need. The group therapist then helps the girls to learn how to incorporate these people into their new narrative and how to reach out to their support network in times of need.

A creative art activity during this session, designed to support this process, is for the group members to create images that represent how they think and feel about the significant people in their lives. As the members share their art with the group, the therapist and the members help each other to explore if and how the supportive people fit into their new narrative. Homework for this session is for the girls to invite the identified person or persons to be their support network by hearing about their new narrative, such that they are a witness. Girls are also to practice incorporating into their daily lives the people who provide them with healthy support. In the next group session, the group members are invited to speak about how they completed their homework assignment; those who need more group support to complete this task are given extra attention. A descriptive outline of this session is in Appendix C.

In session 11, the final intervention of narrative therapy, *taking-it-back*, is discussed. First, the therapist helps the girls to understand that taking-it-back is an opportunity for them to share the experiences, insights, skills, and knowledge that they have gained from the group with other clients or members of the community who share in their struggles with low body-esteem. Then the therapist helps the girls explore what that would look like for each of them. Creating a wisdom manual is introduced to the group as the week's creative art activity (Duba et al., 2010). The girls can contribute works of art, journal entries, or essays that demonstrate their understanding of the unrealistically thin body type that society has determined to be the standard of beauty in the United States and illustrate the ways their environment encourages them to achieve this body type. Girls can also include the reasons why they chose to make a change in their lives and the strategies and motivators they use to help them re-author their narrative and sustain their newly developed positive body-esteem.

These contributions are collected and put together to create a wisdom manual that is shared with the group in the last session. With appropriate approval from every contributing group member, the wisdom manual can be replicated and shared with others.

The homework for the week is to create a journal entry that reflects on their experiences in the group, what they felt the first day of group, how that has changed, what they have learned, what they liked the most and the least about the group, and what they would want someone else struggling with low body-esteem to know. The girls can also create more entries to add to the wisdom manual and bring them to the final session. A detailed outline of this session can be found in Appendix C.

The 12th and final session is used to support the group members to say good bye to each other and to help empower each other to live their new narrative. The group leader assists the members to share their feelings about the end of the group and to complete and review the group's wisdom manual. The members are invited to reflect on their experiences in the group, the work that they have accomplished, the skills and strengths they have developed, and all of the possible resources for positive support that they have available to them. The group therapist then introduces the same poster activity that was done in the first session; however, in this session, the girls are prompted to create a poster that depicts their new positive body-esteem and healthy lifestyle. These posters are shared with the group and the group therapist introduces the idea of the girls keeping these posters as reminders of the work they did in group and of the strengths they possess. The therapists are advised to listen carefully to the girls' newly formed narratives, as they are expressed throughout the group and in this last session. It is important for the new narrative to be positive, helpful, and healthy rather than constrictive and limiting in an unhealthy way (e.g., the teens are

supported to think about themselves with self-compassion towards their inclinations to engage in self-care, rather than with another layer of obligations related to healthy lifestyle habits).

During this session, a short, anonymous questionnaire is administered to them in order to gather feedback regarding the degree to which the girls believe that the group has helped them to re-author their narrative, cultivate positive body-esteem, reduce their use of unhealthy weight control behaviors, and empowered them with the knowledge necessary to sustain a healthy lifestyle (see Appendix E). Assessment tools are recommended as a means for therapists to determine the effectiveness of their group (Corey et al., 2004). This feedback is collected in an anonymous manner and reviewed by the group therapist in private. The group is concluded with everyone saying their final good byes and best wishes. A detailed outline of this session can be found in Appendix C.

Follow-up individual, in-person sessions are held approximately 2 weeks after the concluding group session to conduct a follow-up assessment and to administer a post-treatment questionnaire that is identical to the pre-treatment questionnaire (see Appendix D for an example). Information gathered during the group sessions and the follow-up individual session is used to determine if a participant is in need of further support or treatment in her efforts to achieve her personal goals. If additional care is needed, appropriate referrals are made.

Program Evaluation

During the pre-group individual session, each girl is asked to complete a short, two-part assessment questionnaire (see Appendix D). The first part obtains information on her current, pre-treatment, feelings and beliefs about her body and her environment, and the

second part assesses for symptoms of depression and anxiety, participation in healthy and unhealthy weight control behaviors, and thoughts of or attempts to commit suicide. This same questionnaire is administered during the post-group individual session. As discussed by Corey (2012) and Corey and associates (2004), providing group members with assessment tools is an important feature of the group experience and encourages them to reflect on their experiences in the group and any personal growth that was made. The therapist reviews each girl's self-evaluation with her in the individual sessions: both the pre- and post-assessment can assist the therapist to tailor the intervention and the follow-up referrals to the needs of each adolescent. Progress is highlighted and plans are made for continuing work where needed.

The separate anonymous participant feedback survey (Appendix E) that is gathered during the final session is used to evaluate the success of the group to reach its intended purpose and to make any necessary changes to the group in an effort to continually improve the experience of future participants. Some responses to the individual pre-post assessment questionnaire can be aggregated into pre-post group evaluation data that also assist the group leader to evaluate the effectiveness of the program, overall.

Professional and Ethical Issues

Professionals leading the proposed group are licensed mental health providers, credentialed school counselors, or interns being supervised by licensed or credentialed individuals working within the scope of their practice and seeking supervision or consultation when needed. Therapists should be experienced in leading counseling groups with teenagers, well versed in narrative therapy and art therapy or working with the creative arts in therapy; they also need to understand the benefits of psychoeducation and how to integrate

educational and factual information into the group in ways that are accessible to this age group, interesting, relevant, culturally appropriate, and flexible.

Group therapists working with this population must have clinical experience with adolescents and an understanding of adolescent development, gender development, and the affects the media has on girls. Some of the essential therapeutic skills that group therapists should possess include the ability to express empathy, unconditional positive regard, genuineness, flexibility, and confidentiality (Corey, 2012; Corey et al., 2004). In order to help reduce possible countertransference while conducting this group, therapists should do their own work especially around body image and body-esteem and adapting healthy beliefs and behaviors prior to starting the group. It is also vital that group therapists have the means of providing the necessary art materials for running the proposed group.

Ethical standards of care that should be taken into consideration when conducting the proposed group include informing group members of: their rights as a consumer, the potential risk and benefits of group work, confidentiality and the limits to it, the goals and structure of the group, the option to discontinue their participation at any time, and the rules each member is expected to follow while participating (Corey, 2012). It is also the responsibility of group therapists to discourage unhealthy and self-destructive behaviors outside of the group and encourage and role model healthy, respectful, relationships with other group members. Group therapists should remain professional at all times, maintain confidentiality, set and maintain clear boundaries with group members, and have safeguards in place to minimize potential risks (Corey, 2012).

Socio-cultural Considerations and Other Differences

Like other postmodern approaches, narrative therapy is an appropriate fit for culturally diverse clients due to its assumption that multiple realities exist and that perceived truths are developed as a result of social, cultural, political, and relational experiences. Narrative therapy provides clients with an opportunity to explore their realities and the consequences of them while remaining within their cultural norms. This process allows for clients to deconstruct the meaning they give their lives and the language practices that they use, and to begin to reinterpret their lived experiences and re-author the stories they tell themselves while still remaining true to their values and beliefs. Narrative therapy is very different than most modern therapeutic approaches in that it does not view problems as being an individual issue defined by the dominate culture, rather it assumes that problems exist in a societal context. Through exploring problem-saturated narratives clients gain cultural awareness and understanding of how the dominant culture establishes unrealistic and oppressive expectations for people and how these societal standards have affected them individually (Carr, 1998; Corey, 2012).

A possible cultural shortcoming of narrative therapy that Corey (2012) discussed is that therapists take the stance of a consultant(s) as opposed to an expert(s). Some clients may lose confidence in the therapist if they feel that the therapist is not living up to their expectations of the therapist being someone who provides them with direction and solutions. To help mitigate these reactions and to help instill trust in the therapeutic process, therapists should discuss with clients that, although they are not the expert in how a client wants to live his or her life, they do have expertise in the therapeutic process.

Summary

This chapter proposed a narrative therapy counseling group that integrates creative art exercises and psychoeducation for adolescent girls struggling with low body-esteem. The proposed group aims to increase the participants' body-esteem, reduce their use of unhealthy weight control behaviors, and empower them with the information necessary to sustain a healthy lifestyle by the conclusion of the 12th session. Other goals for the participants include gaining understanding of the context in which their struggles have developed, increasing self-acceptance, identifying personal strengths and abilities, and cultivating new behaviors.

This chapter also includes general guidelines for conducting the 12 sessions, information on administering pre- and post-treatment assessments, the importance of gathering feedback from group participants, and recommendations for professional, ethical, and cultural competency. Chapter IV reviews and discusses some of the limitations of the proposed narrative therapy group as well as a recommendation for further research into the effectiveness of a narrative therapy group that integrates creative art exercises and psychoeducation for the treatment of low body-esteem in adolescent girls. A discussion of the potential implications for mental health providers is also presented.

Chapter IV

Discussion

Chapter I discussed the unrealistically thin body type that is widely accepted in the United States as an ideal despite it only being naturally obtainable by 2% of the women (National Association of Eating Disorders, 2005). The biopsychosocial effects that result from an environment that widely accepts and encourages girls and women to achieve this body ideal were also examined. Chapter II introduced narrative therapy (Carr, 1998; Corey, 2009; White & Epston, 1990) and art therapy (Corey, 2012; Heenan, 2006; Malchiodi, 2007) and reviewed the research that evaluated the application of these approaches to a variety of populations to promote mental well-being (Frisch et al., 2006; Hartz & Thick, 2012; Heenan, 2006; Kelly et al., 2002; Leahy & Harrigan, 2006; Weber et al., 2006). Chapter II also introduced psychoeducation (Corey, 2012) and discussed the effectiveness of implementing it as a means to promote media-literacy (Yamamiya et al., 2005). A review of the research also supported the use of group counseling with adolescents (Corey, 2012) and for the treatment of people with disordered eating behaviors (Burlingame et al., 2004). Chapter III introduced a 12-week narrative therapy counseling group for adolescent girls with low body-esteem that integrates the use of art therapy and psychoeducation. Chapter IV discusses the limitation of this intervention and the implications of the proposed approach for counselors and future research.

Limitations

Consistent with other treatment interventions, the proposed12-week narrative therapy counseling group is not a cure-all for adolescent girls with low body-esteem. Given a review of the research, it seems likely to assume that some participants would be able to re-author

their stories and develop healthy lifestyles, while others might need additional therapeutic intervention and resources. The effectiveness of the proposed group is limited to experience and training of the group therapist, the cost and available resources, and the environmental influences that undermine the message of the group.

Therapeutic training. A limitation to the proposed group intervention is that the group therapist needs to be well versed in the implementation of narrative therapy, creative art activities, psychoeducation specific to the topic, and in group counseling with teenage girls. This requires the therapist to have had successful practice conducting narrative therapy with adequate supervision. The therapist who leads the proposed group needs to have the experience and skills to facilitate art therapy activities that are consistent with narrative therapy interventions; she or he also needs to be knowledgeable of the messages girls receive from their environment regarding the ideal body and how those messages affect them biologically, psychologically, and socially, and be effective in integrating psychoeducation and guest speakers into the group. Finally, given that the success of the group is limited to the success of the therapist, she or he would need to be experienced in successfully leading counseling groups for adolescent girls (Corey, 2012).

Resources. One limitation of any counseling group is the cost. The group needs to be affordable to the population that it is designed to serve, and the therapist running the group needs resources to run this group. For some, acquiring a large enough confidential space, with an adequate table surface, in which to conduct each session may not be easily available. Additionally, in order to keep the group affordable, the therapist may not have the resources to provide the participants with all of the necessary art materials.

Environmental influences. Despite the new knowledge that the participants gain and the skills and behaviors that they develop during the group sessions, they will remain living in the environment that influenced them to develop the beliefs, behaviors, and disorders that lead them to have low body-esteem in the first place. To some extent, the girls may be able to influence their immediate social environment by sharing the knowledge they gained in the proposed group; however, the media and a large part of society will continue to pressure girls and women to once again internalize the hopes of acquiring an unrealistically thin body type in order to be beautiful and powerful.

Gender. Although it is not the purpose of this paper to discuss body-image and body-esteem for boys and men, this is a significant challenge for many males, as well. The proposed intervention is described for the use of treating adolescent girls; however, it can be adapted to be an appropriate treatment for boys (Bearman et al., 2006; CDC, 2006; Field et al., 2005; Neumark-Sztainer et al., 2005; van den Berg et al., 2010).

Implications

This section considers some of the implications of the proposed 12-week narrative therapy counseling group for the field of counseling and future research. It also addresses the implications of integrating a traditional talk therapy approach with an experiential approach and a psychoeducational intervention.

Counseling. This paper provides counselors with a description of a support group that serves as both an early intervention for and prevention of the development of low body-esteem. As stated earlier, the purpose of the proposed group is to support adolescent girls to develop positive body-esteem and to reduce the use of unhealthy weight control behaviors, and to empower them with the knowledge needed to have a healthy lifestyle. More

specifically, the group is designed to have a positive and lasting effect on the girls by assisting them to: (a) recognize the influence that their environment has on their beliefs about their bodies and self-worth, (b) understand that body-esteem is a society-wide problem that affects others, (c) develop coping strategies to help them to navigate through life stressors and societal pressures in a healthy manner, and (d) adopt a healthy lifestyle that supports their physical and mental well-being. The group would also provide the girls with social support and a sense of belonging (Corey, 2012). If this approach is determined to be effective, integrative approaches to prevent the onset of low body-esteem should be made available to youth in all communities. Given the potential negative effects of low body-esteem (Brausch & Muehlenkamp, 2007; Cromley et al., 2012; Green et al., 2009; Kim et al., 2011; Kluck, 2010; Neumark-Sztainer et al., 2010), it is much more cost effective for communities and families to prevent this harm as early as is helpful.

This proposed, integrative approach has another implication for counselors: if it is found to be effective, more counselors would need to be trained and given opportunities to gain experience in leading narrative therapy groups that integrate creative arts activities. They also need to have the education and experience in integrating psychoeducation with talk and experiential therapy. This leads to the need for more research, not only to assess the effectiveness of the proposed approach, but also to assess what most supports therapists to become proficient in this integrated approach with adolescents.

Future research. The short-term and long-term effects of the proposed group need to be evaluated. Ideally, this would be done by qualified group therapists collaborating with researchers experienced in assessing the effects of therapeutic interventions. Although program evaluations would provide some information about the effectiveness of the group,

an empirical research protocol that included randomized controls, validated assessment tools, and longitudinal data would provide the information needed about the lasting effects the proposed group has on adolescent girls with low body-esteem.

In addition to understanding the effects of the integrative approach proposed, a component analysis should also be done. A comparison of the effectiveness of each component is needed (i.e., narrative therapy, art therapy interventions, and psychoeducation – each done in a support group), alone as well as combined, to determine what is most effective for the prevention and treatment of body-image challenges and disordered eating behaviors in girls and women. The degree to which psychoeducation (with and without guest speakers) promotes media-literacy and healthy media consumption also needs to be evaluated. Last, the effects that the media and social environment in the United States have on body-image and body-esteem for boys and men and on their development of unhealthy beliefs, behaviors, and disorders, need extensive attention from the research community.

Conclusion

The constant pressure from the media and society for girls and women to achieve an unrealistically thin body, an ideal that is widely accepted as the standard of beauty in the United States, is greatly influencing the development of devastating beliefs, behaviors, and disorders among females. The proposed group intervention is designed to support the health and well-being of girls by reducing the harmful effects that their environment has on them. Through the use of narrative therapy, girls are guided to re-author any unhealthy personal life stories into healthy ones. The use of art therapy aims at promoting self-exploration and self-expression without the need for language, in a supportive, non-threatening manner. These therapeutic approaches integrated with psychoeducation in a group counseling setting

provide girls with a range of opportunities for learning and developing healthy beliefs and behaviors. As stated, research is needed to affirm the effectiveness of this integrated approach to achieve the desired goals. Nonetheless, this paper provides counselors with enough guidance to implement the proposed group. The proposed 12-week narrative and creative art psychoeducational counseling group is intended to prevent or reduce the negative consequences associated with low body-esteem by helping adolescents to develop more helpful life narratives and healthier life habits.

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Appendices

Appendix A

Consent for Treatment

While I expect benefits from this treatment, I fully understand and accept that, because of factors beyond anyone's control, such benefits or desired outcomes cannot be guaranteed. I have been informed about the possible risks of entering psychotherapy and of being in a counseling group.

I have been also been informed and understand the limits of confidentiality. All information among group members and the therapist is confidential; however, there are exceptions to confidentiality that include:

1. When child, dependent adult, or elder abuse is suspected;
2. When threats of violence are made towards an ascertainable victim;
3. When clients present a danger to themselves;
4. When clients are engaged in a legal proceeding mandating access to client mental health records; and
5. When clients authorize release of information in writing with a signature.
6. Also, under a Federal Law known as the Patriot Act 2001,therapists (and others) are required, in certain circumstances, to provide FBI agents with papers, documents, books, records, and other items; they may prohibit the therapist from disclosing to the clients that the FBI has sought or obtained the items under this Act.

The fee for participating in the group is $5 per session. I will be billed for sessions not cancelled 24 hours in advance.

I understand that I am not obligated to attend counseling for any specific number of sessions and I may choose to terminate counseling at any time. However, I understand that an important part of the therapeutic process is the manner in which my therapy concludes. For this reason, I understand that it may be best to attend the group at least one more session to discuss with the group my reasons for leaving.

I have read and understand the above; I have had the opportunity to discuss all aspects of treatment and I understand the group agreements to my satisfaction. I consent for treatment.

Client Signature _____Date_____

Parent/Guardian Signature_____ Date_____

Appendix B

Group Agreements and Contract

Confidentiality: Complete confidentiality is to be maintained among group members; group members are not to talk about the personal material presented in the group to people outside of the group. Breaking confidentiality may lead to dismissal from the group.

Attendance: Any anticipated absence (other than illness) must be discussed beforehand with the group. Group members are also expected to arrive on time to group, as sessions will begin promptly at 6:00pm.

Leaving the group: Members are free to leave the group at any time; any member who would like to leave the group is encouraged to attend one last session in order to discuss her reason for withdrawal.

Participation: Groups members have a right not to participate in any exercise that they do not wish to join and not to disclose anything that they do not wish to disclose. It is the group member's responsibility to inform the therapist of such. In addition, it is the group member's responsibility to let the therapist know (as soon as possible) if she becomes aware that participation in the group is having a negative or destructive effect. It is the therapist's responsibility to protect group members' rights and to encourage group members' responsibilities.

Violence: No violence will be tolerated. No verbal or nonverbal threats will be tolerated.

Drugs/Alcohol: Members agree not to be under the influence of illicit drugs or alcohol during the group sessions.

Potential Risks of Participation: Participation in this group may bring up a range of feelings, reactions, or personal issues. Some of these might be uncomfortable, and group members should be aware of this potential discomfort prior to agreeing to participate in the group.

I have read and I understand the above, and I agree to these ground-rules as a group member.

Name: _____ Date: _____

Appendix C

12-Week Narrative Therapy Counseling Group

Session One

Supplies needed – art materials (markers, pencils, construction paper, cardboard, tissue paper, glue, paint, tape, clay, etc.), the Consent for Treatment form, and Group Contract.

Welcome – Welcome all of the girls and review the group purpose, goals, rules, and structure of the group one more time. Encourage the girls to ask questions and express any thoughts, feelings, hopes, or personal goals.

Introduction – Ask each girl to introduce herself in a go-around by telling the group her name, age, reason for joining the group, and one unique fact about herself. Prompt a brief open discussion by proposing the question to the girls "What does physical beauty mean to you?" Follow this with "What does healthy mean to you?"

Intervention of the week – Introduce the idea of identifying and naming their personal problem.

Art Activity – Introduce the poster art activity and give the girls 15 minutes to create a poster that names their problem. Play soft music in the background, if you wish, music that does not contain words. When the girls are finished, ask the group members to share what they have created and explain what they believe is their problem. The group therapist listens to each member's explanation and notes the internalized messages they have adopted (Duba et al., 2010).

Discussion – Point out the common theme(s) amongst the group members, highlighting that they share a similar problem. Review the internalized messages the girls use to describe the problem; then, facilitate an open conversation to help them begin to identify what outside of themselves is feeding the problem.

Conclusion – Invite the girls to voice any additional questions, thoughts, feelings, or concerns.

Homework assignment – Ask the girls to pay attention to all of the messages they receive from their environment regarding the ideal body type and ways to achieve it. Who supports the problem of girls striving for an unrealistically thin body type and who benefits, profits, and/or agrees with their pursuit for physical perfection.

Session Two
Supplies needed – art materials (construction paper, magazines, tissue paper, glue, and scissors).

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening. Discuss their experience with the homework assignment and explore anything that came up for them.

Intervention of the week – Introduce the idea of externalizing the problem. Demonstrate how to re-frame the language used when discussing the problem (Carr, 1998, & Corey, 2009)

Art Activity – Introduce the magazine collage activity and give the girls 30 minutes to create a collage using magazine clippings to showcase who they think supports the problem of girls striving for an unrealistically thin body type and who benefits, profits, and/or agrees with girls' pursuit for physical perfection (you may want to play soft music in the background, music that does not contain words). When the girls are finished, ask the group members to share what they have created in as much detail as they would like (Duba et al., 2010).

Discussion – Facilitate an open discussion among the group members by encouraging them to discuss if they agree or disagree with the ideas presented in the collages. You may want to coach the girls about how to disagree respectfully; then, have the girls practice their new skills, if needed. By the girls exploring who supports and benefits from their efforts to achieve the ideal body type, they begin to understand their struggles in the context of society as a whole and are better able to externalize the problem, making it separate from their identities.

Conclusion – Invite the girls to voice any additional questions, thoughts, feelings, or concerns.

Homework assignment – Tell the girls who the guest speaker will be during next week's session: a pediatrician who will talk about health and wellness. Ask the girls to write down three questions that they would like to ask or three things that they would like to learn about health and wellness.

Session Three
Supplies needed – Handouts if provided by the guest speaker.

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening.

Activity– Introduce the guest speaker, a local pediatrician, who has an emphasis in sports medicine and/or nutrition and integrative medicine, who then presents some information on what it means to be healthy and the importance of it and holds an open discussion with the girls for an approximately 75 minutes.

Conclusion – Check-in with the girls regarding their experience with the doctor, any further question or comments they have and what they will most take away from the presentation.

Homework assignment – Assign the girls to pay attention to all of the messages they receive from their environment regarding dieting and healthy nutrition. From what sources are they receiving this information? What do they think and feel when they hear or see this information?

Session Four
Supplies needed – art materials (8.5x11 sheets of paper, teen and women's fashion magazines, glue, markers, paints, pencils, crayons, tissue paper, and scissors).

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening. Discuss their experience with the homework assignment and explore anything that came up for them.

Intervention of the week – Introduce the idea of excavating unique outcomes. Explain to the group that this is an opportunity for them to explore times when an outcome occurred that was unusual based on their original problem-saturated narrative (Carr, 1998, & Corey, 2009). For example, times when they felt good about their bodies, they believed they were beautiful just the way they are, or they stopped pursuing society's ideal thin body type.

Art Activity – Provide the girls with teen and women's fashion magazines to cut up, as well as with art supplies, and two 8.5x11 sheets of paper. The girls are given two tasks: in the magazines, they are to find a girl or woman who represents physical beauty and how they would like to look, and on one piece of paper, they glue this idealized image. On another piece of paper, they create a symbolic image of their inner self when they experienced a unique outcome, when they felt safe, strong, and beautiful from the inside out. This image consists of symbols of their healthy self and does not contain any photos of people. The girls have 30 minutes to complete this activity (you may want to play soft music in the background, music that does not contain words).

Discussion – Invite the girls to discuss their images and to compare and contrast the idealized external image with the symbols of their beauty, strength, and health. Throughout this discussion, uses narrative therapy to help the girls recognize that the unique outcomes are opportunities for them to begin to re-author their narrative (Carr, 1998, & Corey, 2009).

Conclusion – Invite the girls to voice any additional questions, thoughts, feelings, or concerns.

Homework assignment – Assign the girls to create a journal entry to process the unique outcomes that they shared in the group and to further explore other possible, unique outcomes. What did it feel like for them to recognize that there are times that they felt confident, strong, and beautiful? Who were with them? What were they doing? Are there other times they have felt good about themselves from the inside out?

Session Nine
Supplies needed – Handouts if provided by the guest speaker.

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening.

Activity– Re-introduce the guest speaker who then presents a follow-up on the importance of health and wellness and holds an open discussion with the girls for approximately 75 minutes.

Conclusion – Check-in with the girls regarding their experience with the doctor, any further question or comments they have, and what they will most take away from the presentation.

Homework assignment – Ask the girls to create a journal entry exploring who in their day to day life supports them, encourages them, and motivates them to live a healthy lifestyle? Who does not do these things? Who discourages them from living a healthy life style?

Session Ten
Supplies needed – art materials (markers, pencils, construction paper, cardboard, tissue paper, glue, paint, tape, clay, etc.)

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening. Discuss their experience with the homework assignment and explore anything that came up for them.

Intervention of the week – Introduce the concept of *outsider witness* and *incorporation* to the group. Explain to the group that this is an opportunity for them to share their new narrative with others, identify the support they need to move forward, and how to incorporate a support network into their lives.

Art Activity – Supply the group with a variety of art supplies and prompt the girls to create images that represent what they think and feel about the significant people in their lives. The girls have 30 minutes to complete this activity (you may want to play soft music in the background, music that does not contain words).

Discussion – Asks the girls to share their images and their thoughts and feelings about the people they have represented. Through the use of narrative therapy the girls explore how the people in the images fit or do not fit into their new narratives and how they can take steps to incorporate their identified support network into their daily lives.

Conclusion – Invite the girls to voice any additional questions, thoughts, feelings, or concerns.

Homework assignment – Assign the girls to invite the *identified person or persons to be their support network by hearing about their new narrative, such that they are a witness. Girls are also to practice incorporating into their daily lives the people who provide them with healthy support.*

Session Eleven
Supplies needed – all of the material the group members have created thus far in the group and art materials (markers, pencils, construction paper, cardboard, tissue paper, glue, paint, tape, clay, etc.)

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening. Discuss their experience with the homework assignment and explore anything that came up for them.

Intervention of the week – Introduce the idea of taking-it-back. Discuss that this is an opportunity for them to share the experiences, insights, skills, and knowledge that they have gained from the group with other clients or members of the community who share in their struggles with low body-esteem.

Art Activity – Create a wisdom manual as the week's creative art activity (Duba et al., 2010). Each girl can contribute works of art, journal entries, or essays that demonstrate their understanding of the unrealistically thin body type that society has illustrated to be the standard of beauty in the United States and the ways their environment encourages them to achieve this body type. Girls can also include the reasons why they chose to make a change in their lives and the strategies and motivators they use to help them re-author their narrative and sustain their newly developed positive body-esteem (you may want to play soft music in the background, music that does not contain words). These contributions are collected and put together to create a wisdom manual to share with the group in the last session.

Discussion – Facilitate an open discussion for the girls to share how it feels for them to reflect on the progress they have made and the new insights that they have gained. Further inquire about how it feels for them to be creating the wisdom manual to help other people struggling with low body-esteem.

Conclusion – Invite the girls to voice any additional questions, thoughts, feelings, or concerns.

Homework assignment – Ask the girls to create a journal entry that reflects on their experiences in the group, what their feelings were the first day of group, how have they changed, what they have learned, what they liked the most about the group, and what they would want someone else struggling with low body-esteem to know. They can also create additional entries to add to the wisdom manual and bring with them to the final session.

Session Twelve
Supplies needed – art materials (markers, pencils, construction paper, cardboard, tissue paper, glue, paint, tape, clay, etc.)

Welcome – Check-in with the group members regarding their week and review the planned agenda for the evening. Discuss their experience with the homework assignment and explore anything that came up for them.

Discussion – Review the final draft of the wisdom manual and reflect on the experiences each girl had in the group, the work they have accomplished, the skills and strengths they have developed, and all of the possible resources for positive support they have available to them.

Intervention of the week – Introduce the idea of documenting the moment and discuss that by documenting how the girls are feeling, what they have learned, and what they are experiencing in the moment will help them hold onto it for the future (Carr, 1998; Corey, 2009).

Art Activity – The same poster activity from the first session is re-introduced, only this time the girls are prompted to create a poster that depicts their new positive body-esteem and healthy lifestyle. The girls have 30 minutes to complete this activity (you may want to play soft music in the background, music that does not contain words). These posters are shared with the group and any thoughts or feelings are discussed. Introduce the idea of the girls keeping these posters as reminders of the work they did in the group and of the strengths they possess.

Conclusion – Administer the Participant Feedback Survey, instruct the group to fill it out anonymously, ask a volunteer to collect the surveys and put them in an envelope, leave the room for 10 to 15 minutes while the girls complete the surveys, and return to the room once all of them have been collected and placed in an envelope. Conclude the group with everyone saying their final good byes and best wishes.

Appendix D

Pre- and Post-Treatment Assessment Questionnaire

Part I

Do you think you need to lose weight? Yes No Maybe

Do you think you need to gain weight? Yes No Maybe

How would you rate your body?

1	2	3	4
I hate it	It's okay	It looks good	I love it

How long have you rated yourself this way? _____

Circle the image that best represents the way you see your body:
Insert the nine images of women's body that vary in size here from Thomas and Gray (1995, p. 263) assessment scale.

Circle the image that best represents your ideal body type:
Insert the nine images of women's body that vary in size here from Thomas and Gray (1995, p. 263) assessment scale.

Who tells you that this is the ideal body type?

_____

What is you biggest fear? _____

Check any of the following if you have done it:

- Watched the amount of calories, fat, carbs, and/or sugar you eat?
  Do you still? Yes No How often?
- Exercised at a moderate level a few days a week?
  Do you still? Yes No How often?
- Restricted the amount of food you consume?
  Do you still? Yes No How often?
- Fasted for other than religious or cultural reasons?
  Do you still? Yes No How often?
- Consumed an abnormally large amount of food in one siting?
  Do you still? Yes No How often?
- Vomited after eating?
  Do you still? Yes No How often?
- Taken laxative or diuretics?
  Do you still? Yes No How often?
- Taken diet pills or appetite suppressants?
  Do you still? Yes No How often?
- Used steroids?
  Do you still? Yes No How often?

- Vigorously exercised most days of the week?
  Do you still? Yes No How often?

Part II

Do you feel sad, hopeless, or uninterested in typical daily activities? Yes No

If yes, how many days per week do you feel this way? _____

How many months have you felt this way? _____

Do you usually enjoy spending time with friends, participating in sports and/or hobbies? Yes No

If no, how often do you not enjoy these activities? _____

How many months have you felt this way? _____

Check any of the following that you would use to describe your sleep patterns:

- I can't sleep enough.
- I struggle to stay asleep. I wake up frequently throughout the night.
- I struggle to fall asleep but can stay asleep once I do.
- I sleep too long.
- I take naps during the day because I am very tired.

Do you feel like you have a lot of extra energy that you cannot get rid of, feel anxious, or keyed up? Yes No

If yes, how many days per week do you feel this way? _____

How many months have you felt this way? _____

Do you feel irritable, on edge, or easily angered? Yes No

If yes, how many days per week do you feel this way? _____

How many months have you felt this way? _____

Do you find yourself unnecessarily or continuously worrying about things? Yes No

If yes, how many days per week do you feel this way? _____

How many months have you felt this way? _____

Have you ever felt like you were having a panic attack? Yes No

If yes, what did you experience? _____

_____

_____

When was the last time you experienced this? _____

How many times have you experienced this? _____

Have you ever thought about hurting yourself? Yes No

If yes, how often? _____

When was the last time? _____

Have you ever thought about killing yourself? Yes No

If yes, how often? _____

When was the last time? _____

Have you ever tried to kill yourself? Yes No

If yes, how many times? _____

When was the last time? _____

Appendix E

Participant Feedback Survey

Please rate (by circling) the group and leadership qualities according to the following criteria:

1	**2**	**3**	**4**
Poor	**Okay**	**Good**	**Great**

1) The goals and purpose of the group were clearly defined

1	2	3	4
Poor	Okay	Good	Great

2) The group was successful in helping me feel better about my body

1	2	3	4
Poor	Okay	Good	Great

3) The group was successful at helping me reduce the use of unhealthy weight control behaviors

1	2	3	4
Poor	Okay	Good	Great

4) The group provided me with the information I need to sustain a healthy lifestyle

1	2	3	4
Poor	Okay	Good	Great

5) The group helped me feel better about myself

1	2	3	4
Poor	Okay	Good	Great

6) Enough time was provided for processing and discussing my experiences during the group

1	2	3	4
Poor	Okay	Good	Great

7) The group therapist was knowledgeable about the subject

1	2	3	4
Poor	Okay	Good	Great

8) The group therapist was empathetic, non-judgmental, and inviting

1	2	3	4
Poor	Okay	Good	Great

9) What was your favorite part of the group process?

10) What was you least favorite part of the group process?