Treatment of Anorexia Nervosa: A Narrative Therapy Approach

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This Clinical Research Project by Katherine Shaw, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai‘i School of Professional Psychology at Chaminade University in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

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Hawai‘i School of Professional Psychology at Chaminade University – 2020

Anorexia nervosa (AN) is characterized by low body weight, fear of becoming overweight despite weight loss, and a distorted body image. Current understandings of the etiology of anorexia are still widely unknown and there is little empirical evidence to determine best treatment practices. The various findings in the literature regarding the best way to treat AN, the multidisciplinary teams involved and treatment atmosphere utilized to treat this population, suggest that inconsistencies in treatment is likely to continue. It therefore seems essential that research continues in the treatment of AN and empirically validated manuals become available for those working with this population. The purpose of this study is to create a treatment manual for AN that is grounded in a narrative therapy orientation.

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CHAPTER I. INTRODUCTION

Anorexia nervosa (AN) is characterized by low body weight, fear of becoming overweight, and a distorted body image. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) of the American Psychiatric Association (2013) use the following criteria to diagnose anorexia nervosa: refusal to maintain a minimally normal body weight (body weight less than 85% of that expected) or failure to make expected weight gain during growth periods; an intense fear of gaining weight or becoming fat; a distorted view of one's body weight or shape, unnecessary influence on self-evaluation, or denial of the seriousness of their low body weight; and amenorrhea—absence of at least three consecutive menstrual cycles.

I have had personal experience with this disorder, and although never officially diagnosed, the possibility of being separated from my family and placed in an inpatient treatment program was, and remains, a daunting memory. This personal experience led to my interest in exploring current AN research and practice, including research into the potential benefits of alternatives to inpatient treatment. I remember the feelings of ambivalence I had towards my eating disorder. I often had a love/hate relationship with weight loss as I could see how worried my friends, family and teachers became, however this was not enough to alter my restrictive eating behaviors or attitudes about my own body. When I looked in the mirror, I saw someone who needed to lose weight and when I look back at pictures now this is a startling fact, as I can see just how underweight I had become. This demonstrates my distorted body image, which often accompanies AN. The hold this disorder had over me is something I still reflect on and therefore is an area of interest for me. Because I know the powerful and detrimental effects of AN, I have empathy and understanding for those struggling to overcome it.

Rationale

Current understandings of the etiology of anorexia are still widely unknown and there is little empirical evidence to determine best treatment practices. In a literature review done by Meads, Gold and Burls (2001), just eight articles were found that provided information on whether inpatient treatment was more effective than outpatient care and of these eight, there was considerable variation in the data and conclusions were tentative at best. This literature review concluded that more research was needed to assess the efficacy of both inpatient and outpatient care (Meads et al., 2001).

The various findings in the literature regarding the best way to treat AN, the multidisciplinary teams involved and treatment atmosphere utilized to treat this population, suggest that inconsistencies in treatment is likely to continue. It therefore seems essential that research continues in the treatment of AN and empirically validated manuals become available for those working with this population.

Purpose

The purpose of this Clinical Research Project is to create a treatment manual for AN which focuses on utilizing narrative therapy techniques. Its goal is to demonstrate that the use of narrative therapy would enhance the treatment of AN psychopathology and reduce relapse. An outline of the manual will be provided as well as a suggestion for assessment procedures to assist clinicians in determining outcomes of this manual.

Research Questions

1. What is Anorexia Nervosa and what are the effective ways to treat people who are diagnosed with Anorexia Nervosa?

2. What is Narrative therapy and how can it be used as an effective treatment in an outpatient setting for women who have been diagnosed with Anorexia Nervosa?
3. What are some of the strengths and limitations of incorporating Narrative therapy into treatment with women who have been diagnosed with Anorexia Nervosa.
4. What would a treatment module look like?
5. Will the use of a Narrative therapy orientation provide an effective outpatient treatment option for women with AN?

Significance of the Study

This study is significant because of the life-threatening nature of Anorexia Nervosa. Therefore, the stakeholders are those suffering from AN, their loved ones, training faculties and researchers, and those who are treating this disorder. There is a lack of consensus among health care providers on the best treatment practices for this disorder. The increase in popularity of treating patients on an outpatient basis has allowed the reservation of inpatient facilities for the chronically ill. However, it has been widely argued that inpatient treatment is more impactful than outpatient treatment. Due to the difficulty in researching anorexia nervosa treatments, answers are not clear. Therefore, it is important to continue to study this disorder and the effectiveness of different treatment modalities.

There are many reasons why the treatment of AN is difficult. One reason is that patients with AN often see their disorder as a part of their identity (Gorse et al., 2013; Gulliksen et al., 2012; Paulson-Karlsson, & Nevonen, 2012). Ambivalence to treatment and recovery is often expressed when such loss of identity is seen as at risk by the patient. Therefore, something as basic as weight gain leads the patients to feel a loss of their identity and therefore triggers

ambivalence to recovery or results in a sudden refusal of treatment. In the qualitative study conducted by Gorse et al. (2013) recovery was seen by patients as an unknown - that it could result in the patients abandoning a part of themselves. Further, a qualitative study by Paulson-Karlsson and Nevonen (2012), to determine treatment expectations of a group of women, found that these participants wanted to see themselves as different than their disorder and wanted to be seen by others in this way as well, an indication that identity served as an important factor in treatment and recovery.

Both outpatient and inpatient treatment programs struggle with the issue of fear of recovery and loss of identity, and there is no clear evidence that one modality is better than the other at addressing these ambivalence factors. While inpatient programs offer a more intensive and intrusive treatment program, these fears, if not addressed will impact response to treatment in the same capacity as patients in a less intrusive outpatient treatment program. The issue then becomes less about treatment modality (inpatient vs. outpatient) and more about the responsiveness of therapists to address and combat ambivalence. Narrative therapy allows for this level of responsiveness due to its fundamental nature of assisting patients to identify multiple storylines. Additionally, by utilizing and focusing on externalization, their identity can be viewed as separate and distinct from their illness.

CHAPTER II. LITERATURE REVIEW

How does one treat AN? What is the best practice? Are inpatient programs more effective than outpatient programs? These are just a few of the questions that plague AN research.

Anorexia Nervosa History, Characteristics, and Statistics

AN in the western world dates back to the 12th century, when religious women (most famously Saint Catherine of Siena) fasted and generally denied themselves food as a spiritual denial of the body and purification of the mind (Psychology Today, 2011). There are also descriptions of "wasting disease" described in 17th century texts. The disorder was first called AN (Latin for nervous absence of appetite) by Sir William Gull, personal physician to Queen Victoria, in a paper published in 1873, which established eating disorders firmly in the field of psychiatry. By the late 20th century, AN was described as an endocrinal disorder and treated with hormones. An important contribution to the research literature came in 1973, in a book written by Hilde Bruch, who provided case histories covering clinical practice over several decades. At this point, the public became more aware of the disorder and this resulted in a rapid increase in diagnosed cases. Such increases in the number of AN cases have increased even more markedly since the beginning of the 21st Century, with increases of close to 50% in the last decade in some age groups now being reported (Psychology Today, 2011).

Current understandings of the etiology of anorexia are still widely unknown and there is little empirical evidence to determine best treatment practices. In a literature review done by Meads et al., (2001), just eight articles were found that provided information of whether inpatient treatment was more effective than outpatient care and of these eight, there was considerable variation in the data and conclusions were tentative at best. This literature review was conducted

because it has been argued that inpatient treatment is the gold standard. Therefore, the aim of this study was to determine the effectiveness of inpatient treatment in regards to care and cost-efficiency when compared to outpatient treatment. This literature review concluded that greater research is needed to assess the efficacy of both inpatient and outpatient care (Meads et al., 2001).

Prevalence of the Disorder

Due to the lack of eating disorder specialists in Canada, I have chosen to focus AN statistic's on Canada. Canadian statistics highlight just how important it is for the creation of effective treatment manuals in order to avoid people from falling through the cracks or receiving ineffective treatment. Few hospitals in Canada have the resources to address mental health issues associated with eating disorders; of 4100 psychiatrists practicing in Canada, only 12 specialize in treating eating disorders and hospital wait times for these potentially fatal disorders can be up to a year (LeBlanc, 2014).

According to Statistics Canada (2013) anorexia nervosa impacts between 0.3% and 1% of women (or about 150,000 across Canada), although this number may be inaccurate due to underreporting. Little information is available regarding male sufferers, although the numbers are estimated as only 10% of the total group with this disorder. Researchers from Sainte-Justine Children's Hospital and University of Montreal studied 215 children between the ages of 8 and 12 with eating problems. What they discovered was that 95% of the children displayed restrictive eating behaviors, 69.4% feared weight gain and 46.6% identified as "fat." (Ellis, 2014). A report from the standing parliamentary committee on the Status of Women in Canada estimates that 1,500 Canadian women die from AN in Canada each year (LeBlanc, 2014). The

number of hospitalizations increased significantly among young girls in Canada for eating disorders from 2006 through 2013. In fact, the number of hospitalizations in women of this age group has risen by 42% since 2013 (LeBlanc, 2014). This troubling trend has led physicians and advocacy groups to question the number of treatment spaces actually available and/or how many programs have extensive wait lists. In fact, clinics and hospitals that specialize in eating disorders have experienced a rise in the numbers of all age groups – from five years of age through adulthood- seeking help for eating disorders (Pinhas, Morris, Crosby, & Katzman, 2011). While hospital resources are scarce, community-based help is virtually non-existent. Non-profit groups supporting treatment of eating disorders operate with little or no government funding and almost exclusively on a volunteer basis (LeBlanc, 2014). Knowledge that those who are struggling with an eating disorder may be turned away from treatment due to lack of resources is also troubling. The seriousness of AN, which can be fatal, makes treatment of this disorder a burgeoning public health issue.

The cost of inpatient care and current long wait times for admission into hospitals make studying and implementing outpatient care all the more important. Dr. Blake Woodside who is the co-director of the Eating Disorders Program at Toronto General Hospital, noted the deficiencies in regards to specialized treatment programs in some parts of Canada, despite the fact that eating disorders often have a 15 percent death rate (Pinhas et al., 2011). The protracted wait times for hospital admission are even more troubling because it has been well-established that early intervention – counseling for girls, especially in an outpatient setting - can be a very effective prevention tool at a point of disordered eating rather than a full-blown disorder (LeBlanc, 2014).

Diagnosing AN

The *DSM 5* (2013) clinically diagnoses anorexia nervosa if the following criteria are met: body weight less than 85% of that expected; intense fear of gaining weight or becoming overweight; a distorted body image which inaccurately inflates size and shape, unnecessary influence on self-evaluation based on physical appearance alone, or denial of the seriousness of their low body weight; and the absence of at least three consecutive menstrual cycles (American Psychiatric Association, 2013).

Correctly diagnosing AN can be difficult. Although it would appear to be noncontroversial, there is no agreement on how to assess weight loss. Some focus on total weight loss subtracted from an originating high weight, while others determine it by calculating weight loss below a normal body mass index. The *DSM-5* has moved away from a cutoff weight point. This allows for more subjectivity and the need for clinical judgement, which has both benefits and downfalls. When there was a set weight cutoff (found in the *DSM-IV*), many patients would not meet the criteria and therefore not receive a diagnosis. However, with increased subjectivity, clinicians may disagree or misdiagnose patients. This may be both confusing and frustrating for those suffering from AN and their families. Many of the assessment tools, which are reviewed below, are self-report measures and therefore denial of symptomology may cloud the diagnostic picture.

The psychological criteria for AN is also a contested issue. Modern technology has enabled those suffering from AN to fool doctors by learning and concealing symptoms associated with this disorder. For example, they will engage in behaviors that are indicative that

they fear weight gain, such as dieting, refusal to eat, and extreme workout regimens all while denying that fear. That requires doctors to diagnose through observation alone which leads to difficult judgment calls. Psychological assessments have demonstrated that a high percentage of patients with AN display self-esteem issues related to inadequacy and problem solving, they lack self-confidence and fear physical change due to maturity (Halmi, 2005). Patients that suffer from AN often identify their thinness as the measure of evaluating their dieting accomplishments. The obsession of weight loss and being thin allows women with AN to avoid thinking about other life problems and acts as a defense mechanism. Acknowledging the severity of their unhealthily low body weight requires that they must also undergo behavioral changes. That can often be a tremendous and frightening prospect. Evaluating and assessing the symptom of amenorrhea is challenging due to the problems related to getting an accurate history of menstrual patterns. Birth control medication can complicate patient history of menstrual cycles; pairing that issue, and the fact that there are cases of women of extremely low weight who report menstruation, supports excluding amenorrhea as a factor of diagnosing AN (Halmi, 2005).

Additionally, the etiology of AN is not well known. According to the *DSM-5* (2013), those who display obsessional traits in childhood or develop anxiety disorders are more likely to suffer from anorexia nervosa (American Psychological Association, 2013). There is an association between how much thinness is valued in a particular society and the prevalence rates of AN in that society. Occupations that encourage thinness, such as modeling, are also associated with increased risk. There is a biological component of AN which means that people who have close relatives suffering from this disorder are at greater risk. There are various brain

abnormalities that have been discovered in anorexia nervosa through the use of functional imaging technologies, such as positron emission tomography and functional magnetic resonance imaging. However, it is unclear whether these brain abnormalities are due to malnutrition or the disorder itself. Research has shown that patients with AN showed abnormality in the brain regions of the basal ganglia, frontal cortex and the posterior cingulate nodes. Poor insight, which is common in AN, is correlated an elongated path length in the right caudal anterior cingulate and the right posterior cingulate (Zhang et. al. 2016). Poor insight may be why those with AN are not able to see the serious danger they are putting themselves in by starving themselves. While this research offers some new insights, much work is needed in this area.

Many of the assessment tools have been updated to include specific scales to measure each of the psychological traits. Three eating disorder traits of AN psychopathology cited most frequently in the current research are: drive for thinness, body dissatisfaction, and perfectionism (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013;; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). A drive for thinness is an excessive concern with dieting, preoccupation with weight, and immense fear of weight gain (EDI-3 subscale definition). Body dissatisfaction is defined by the EDI-3 as not being satisfied with one's physical appearance. Perfectionism is defined as not being satisfied by anything less than perfect.

Comorbidity

Patients diagnosed with AN are likely to suffer from one or more additional psychiatric disorders (Pollice, Kaye, Greeno & Weltzin, 1997). The most studied is the relationship between AN and depression. Many behavioral similarities exist between starvation and symptoms of depressive disorder. It is estimated that as many as 91% of those diagnosed with AN suffer from

depressive disorder (Eckert, Goldberg, Halmi, Casper, & Davis, 1982; Hudson, Pope, Jonas, & Yurgelun-Todd, 1983; Strober & Katz, 1988).

A study by Pollice, Kaye, Greeno and Weltzin (1997) conducted a study comparing depression, anxiety and obsessionality in anorexic patients while they were underweight and then again at different stages of weight return. What they discovered was that women suffering AN exhibited increased symptoms of the three traits when compared to healthy controls. Additionally, scores were highest among underweight patients. However, some symptoms continued at high levels in recovered patients compared to health controls. Their findings indicated that depression is amplified by degree of thinness and that those who recovery no longer suffer from malnutrition. Anxiety and obsessionality showed the same pattern however these comorbid symptoms tend to continue after weight restoration and long-term recovery, although to a lesser degree. This suggests that there may be underlying psychological traits that will need to be addressed separately from AN. It is also important to note that the major comorbidities of AN (depression, anxiety, and obsessionality) potentially contribute to poor AN prognosis, which may worsen these symptoms. This vicious cycle is important to understand as a treating clinician and various assessment measures for depression and anxiety may be helpful with patients who have been resistant to various treatment programs.

A case study by Pryor, Marin, and Roach (1995) highlights the possible relationship between obsessive-compulsive disorder (OCD), trichotillomania, major depression, and AN. The patient was an 18-year-old female. Her scores on the Eating Disorder Inventory (EDI) were elevated, indicating that she meets diagnostic criteria for AN. She presented with compulsive habits and obsessive thoughts associated with her eating disorder, however, she also had

obsessions and compulsions that did not relate to AN. At 13 years old she began pulling out her hair which she stated gave her a sense of control. She first exhibited signs of depression at 15; symptoms including loss of interest in daily activities, low energy, misplaced guilt, and suicidal ideation. The treatment consisted of 10 weeks of outpatient cognitive behavioral and interpersonal psychotherapy. Treatment resulted in a return to her normal weight, eating patterns and appropriate amounts of exercise. Nevertheless, she displayed an increase in OCD symptoms and persistence of trichotillomania. She developed acceptance issues, worries of not being liked, along with an irrational fear of dying. She dropped out of school which resulted in greater isolation at home. This case study demonstrates the difficulty in treating AN in the presence of comorbid disorders. While symptoms of AN improved, the patient continued to struggle with mental health concerns which indicate that she is at a higher risk for relapse of AN symptomology.

Phenomenologically, OCD, AN and trichotillomania all involve involuntary and persuasive thoughts leading to dysfunctional behaviors (Pryor et al., 1995). They may have common pathophysiology. It is suggested through neurobiological findings that eating disorders could be a variant of OCD and therefore shares similarities in abnormal serotonergic functioning (Kaye, Weltzin, Hsu, & Bulik, 1991). Due to these similarities, a question the authors of this case study had was whether this patient's OCD symptoms and trichotillomania made her susceptible to AN. Or alternatively, were trichotillomania and AN merely manifestations of OCD. Causation and directionality are unclear.

In a study by Herpertz-Dahlmann and Remschmidt (1993) they investigated whether the severity of depression symptoms was related to the outcome of AN at a follow up after 3 years.

They found during that follow up a correlation between eating and depressive symptoms. In other words, at the follow up it was far more likely that a patient suffered from AN if they also exhibited major depression than those patients without major depression. The results indicate that depression at may be related to social and economic dysfunction and not just from malnutrition and starvation. Socioeconomic dysfunction comprises the quality of the relationship with family and other important people, social activities, and satisfaction with job or school. They found that the poorer the social adaption the more depressed patients feel, and vice versa. Therefore, it may be hypothesized that depression is not just a common feature of eating disorders but is likely to coexist with many mental health disorders.

The trait of perfectionism has an interesting and complex impact on both affective symptoms and AN. A study by Haynos et al. (2018) showed the importance of subtyping anorexics according to their perfectionistic dimensions. They found four subgroups; moderate maladaptive perfectionism, high maladaptive perfectionism, high adaptive and maladaptive perfectionism, and low perfectionism. As expected, the low perfectionism group had less severity of both AN and affective symptoms. However, the high adaptive and maladaptive perfectionism group endorsed higher levels of AN symptoms than both the moderate and high maladaptive groups. This group demonstrated unhealthy eating patterns but had less mood disturbances than those in the maladaptive only groups. These results indicate that the type of perfectionism an anorexic patient has may help determine the likelihood of them having a comorbid affective disorder. The authors state that the reason for this result is unclear, however it may be that traits of perfectionism are causing patients to be more fulfilled by their eating disorder, resulting in fewer mood difficulties reported. This study highlights the importance of

heterogeneity in variables within AN. These results suggest that there may be benefit to utilizing different intervention approaches as different subsets of individuals will respond differently to treatment. This study makes a strong case for the need of new treatment programs and is additional evidence that a "one size fits all" treatment approach is ineffective in conceptualizing and treating AN (Haynos et al., 2018).

A study by Junne et al. (2016) investigated the relationship of body image (a central characteristic in AN) with symptoms of depression and anxiety. What they discovered was that how one perceived their body were correlated directly with depression and anxiety throughout all stages of treatment. This demonstrates that body image, more so than AN, is associated with affective symptomology. In fact, body image had such a strong correlation with depression and anxiety that the researchers found that poor body image at the beginning of treatment predicted depression and anxiety at follow-up. Body image disturbances should therefore be explicitly targeted during treatment, especially since the likelihood of comorbidity is heightened in those cases of poor body image.

Assessment Tools

Assessment tools that involve structured clinical interviews such as the Eating Disorder Examination (EDE) are the best way of diagnosing AN and are therefore considered "*gold standards*" (APA, 2006). However, they are not always utilized by clinicians because additional training is required and they take a long time to administer. Due to these factors they are used more in research than in clinical practice, even though they are valid and reliable measures for diagnosis (Surgenor & Maguire, 2013). The benefit of using interviews is that they provide the

researcher with such additional information as non-verbal communication, and also allows researchers to ask spontaneous follow up questions to retrieve further information on topics they see as meaningful to the research question. The EDE, and its self-report version, the EDE-Q, provide two types of data. First, they measure behaviors related to eating pathology and can be as detailed as listing the amount these behaviors occur during the day, week and month. The second set of data captures the severity of AN symptomology using subscale scores; the subscales are Restraint, Eating Concern, Shape Concern and Weight Concern. A limitation of this measure is that the EDE and EDE-Q are not necessarily aligned which results in discrepancies of the symptoms being assessed.

The benefit of self-report questionnaires is that they are self-explanatory, therefore requiring minor direction to administer. Another positive attribute is that they can be administered quickly. However, such questionnaires differ in their application. Shorter measures such as the Eating Attitudes Test (EAT-12; EAT-26) are beneficial in primary care where providers question the presence of an eating disorder and use these measures to determine if there is a need for additional evaluation (Surgenor & Maguire, 2013). Self-report questionnaires are less useful in specialized programs when the need is for in depth information about eating disorder pathology and severity. The Eating Attitudes Test is used to assess for "eating disorder risk" and is used to gather information to identify if a person should seek a more comprehensive assessment. The SCOFF is a 5-question and is also a screening tool. If the person answers 'yes' to two or more of the questions it indicates that they should seek a more comprehensive assessment. At this point, a longer self-report measures would be useful (for example, Eating Disorder Inventory (EDI-3), Eating Disorder Examination Questionnaire (EDE-

Q), and Yale-Brown-Cornell Eating Disorders Scale (YBC-EDS) because it measures multiple risk factors and psychological disturbances associated with AN. Helpful information about psychological symptoms can be gathered from these measures that aids the clinician in determining diagnosis and treatment planning (Surgenor & Maguire, 2013). As standardized measures, they can be useful in assessing symptom change. The limitation of using self-reporting measures is that they rely on the honesty of the participants, as well as their introspective ability. That is, social desirability (the instinct by the participant to provide only answers that they think the researcher wants) may be a factor in participant responses.

Gender Differences

As stated earlier, males are estimated as only 10% of the total group with this disorder. The higher prevalence rate of AN in women has led researchers to investigate causative influences that may account for these differences. Strober et al., (2006) conducted a study that compared symptoms, personalities, and recovery rates between females and males with AN. They found that women had much higher rates of relapse and higher concerns over weight and eating at a 1 year follow up. This study illustrates that not only do more women than men suffer from this disorder, they also experience higher morbidly rates. Women appear to be 'hit harder' by AN and are more likely to be resistant to treatment.

A study by Darcy et al., (2012) found that males with AN had lower scores on some measures of the Eating Disorder Examination (EDE). Particularly, males scored lower on the measures of Shape Concern and Weight Concern. These are measures of core symptomology of AN and address a desire to lose weight. The authors conclude that this may indicate that males are less concerned with attaining a low weight and being "thin" and are instead driven by a

desire to have a muscular "fit" body. Women have a more socially constructed "shape" ideal than men and therefore concern over weight may be more prevalent in females with AN than males with AN.

A study by Burke et al., (2018) investigated brain stimulation using functional magnetic resonance imaging during a Body Perception task in both men and women. They found that images of other people's body produced more attention in men whereas images of one's own body produced more attention for women. This may explain why women are more susceptible than men to insecurities involving one's own body image.

One possible explanation of the gender disparity of this disorder is societal expectations placed on women to be thin. Andersen and DiDomenico (1990) argue that media advertising is a major source of persuading women to be concerned about their weight. They compared the content of advertising in magazines aimed at women versus those aimed at men and found that female magazines had many more ads about dieting. They discuss the question of whether media creates or simply reflects western society's overvaluation of thinness in women. Regardless of the answer, it is important to understand cultural values of thinness when treating women with AN.

Culture of Thin

Roughly half of all girls and women report dissatisfaction with their physical appearance in regards to figure, shape and weight (Bearman, Presnell, & Marinez, 2006; Montheath & McCabe, 1997). Why is this number so high? One factor is the increasingly thin ideal dominating western society. This 'thin ideal' can be seen across various forms of media including movies, cartoons, female video game characters and advertisements. Often these

depictions of women are unrealistic and do not represent a healthy weight nor do they represent the female population. Because media's portrayal of women is so skewed, it may lead women to create unrealistic expectations and behaviors aimed at meeting these beauty standards. A study by Grabe, Ward, and Hyde (2008) conducted a meta-analysis that examined the links between media exposure to poor body image, the belief that being thin is ideal, and eating pathology. They included 77 studies in this analysis and wanted to include both experimental laboratory studies and naturalistic, correlational studies. The reason the authors wanted to include both types of research designs in their meta-analysis is that both designs come with limitations. In a laboratory setting, the artificial setting limits external validity while correlational designs cannot provide directionality and causation in findings. They suggest that by combining the results of both types of studies, it will provide more conclusive evidence that media images have a negative image on body dissatisfaction. Their findings provided strong support that exposure to media depicting the thin ideal is associated with vulnerability to disturbances related to body image. They also found a link between media images and internalizing the thin ideal and eating behaviors. Internalizing the thin ideal was larger in correlational studies, suggesting that it takes time to develop and therefore may be hard to capture in a laboratory setting. This has major implications for treating clinicians working in western society's as media is pervasive and exposure to the thin ideal begins at a young age.

So, are western media images really that bad? A study conducted by Saraceni and Russell-Mayhew (2007) examined the changing body shape of Playboy models. They compared centerfolds from January 1960 to December 1999. They included body measurements of bust size, hip size, waist size, height, weight and age. They found that centerfold bust, and hip sizes

have decreased significantly since 1960. They found that weight stayed the same, but what was notable is that the models height increased an average of 3 inches. They also found that as time went on there was less variability in body shape with models and in the 1980s and 1990's models were excessively thin. This may signal that what is deemed acceptable by society's standards has narrowed and people are becoming less tolerant of female bodies that deviate from the 'culture of thin'. This study demonstrates that not only is western society promoting an unrealistic body image for women, but that it has gotten worse over time. The culture of thin is therefore skewing society's idea of what normal is and this can have a very damaging impact on those suffering from AN. It is important to include this cultural context into our conceptualization and treatment of women with AN. While it is impossible to completely shield patients from damaging images, it may be helpful in treatment to deconstruct this cultural beauty standard.

While there is no doubt western society subscribes to a thin ideal, the internalization of this thin ideal may vary from patient to patient. Suisman et al. (2012) investigated the degree that environmental and genetic factors have on influencing the belief in the thin ideal. They conducted a twin study in order to capture the influence of genetics. They found significant genetic and nonshared environmental influence on internalization and minimal influence from shared environment. These findings suggest that genetic predispositions play a large role in who internalizes the thin ideal and who does not. One explanation of why genetic traits contribute to the likelihood of internalization is personality, such as perfectionism. The fact that shared environment had little impact on internalization suggests that exposure to thin ideal media is only

risky for those who are predisposed genetically. Therefore, the amount of damage done by media images varies greatly from one person to the next.

A study conducted by Ahern, Bennett, and Hetherington (2008) corroborates the above findings. They examined whether young women who make an association between being underweight and having positive attributes have eating disorder symptomology. They did this by utilizing a weight based implicit association test and self-report measures of body dissatisfaction, thin ideal internalization, and eating disorder symptoms. The results from this study suggested that women who attributed underweight models with positive attributes also had higher scores on the measure of drive for thinness, which is a core construct in AN. A study by Ashikali and Dittmar (2011) discusses how the media primes us to make the association of being thin with other positive attributes of 'the good life'. Often media portrays thin women and material goods in the same advertisement, therefore blending the two concepts together. In this way, the association of being thin and being wealthy is made, which may result in women believing that being thin equates to being happy and fulfilled. This link may further lead to the internalization of the thin ideal since happiness is universally strived for. In their study they found support that women make the association between materialism and the thin ideal. Materialistic priming heightened women's perceptions of the importance of their appearance to their identity. This suggests that women who focus on materialist values tend to see their appearance as the most important part of their identity. Additionally, materialistic priming activated women's negative thoughts and feelings about their body when they saw thin models. Therefore, materialistic values may be a significant vulnerability factor in understanding the impact of thin ideal media on women's body image.

There is evidence to suggest that the culture of thin is becoming more common in non-western countries due to globalization and international media. In the past, the prevalence of eating disorders in non-Western cultures was lower than that in Western cultures. Witcomb, Arcelus, and Chen (2013) discuss the factors involved in the rise of eating disorders in non-western countries. One important factor they found is that the increasing societal belief in the thin ideal is correlated with higher rates of eating disorders. Many of these countries are focusing on treatment, however the authors make a case for the benefits of prevention strategies. Due to the link between the internalization of the thin ideal and development of eating disorders, prevention programs should focus on addressing the concept of the thin ideal and body dissatisfaction. They argue that learning to be critical of the media would be beneficial. The rise of the Internet has exposed youth in non-western countries to western cultural norms and it is important for women to understand how images can be modified in programs such as photoshop.

Professions Associated with Higher Risk of AN

As discussed above, the culture of thin in Western society has resulted in the internalization of the thin ideal in young women. But are women in certain professions more at risk? A study by Ringhma et al., (2006) examined the prevalence and severity of eating disorders among professional ballet dancers. In their study they found that 83% of dancers reported symptoms of AN and met criteria for a diagnosis at some point across their lifetime. Additionally, they found that dancers looked more alike to eating-disorder individuals than to a control group of individuals on eating pathology measures. This indicates that a worryingly high rate of dancers meet criteria for eating disorders and women in this profession are at high risk. Dancers were similar to eating disorder individuals on measures of psychological correlates,

indicating that disorder eating in this group was more than just to enhance job performance. Ballet dancers are under extreme pressure to perform just like any other professional sport. However, the culture of thin is amplified in this profession, as dancers are heavily critiqued on their appearance. Competition is high and thinness is preferred, which leads young women to push themselves to the extreme in order to maintain their job. Additionally, coaches and teachers may put undue pressure on dancers, and this may lead to feelings of inferiority. A study by Ravaldi et al., (2003) found that poor body image was more common in dancers than in gymnasium users. Therefore, body dissatisfaction is not a result of participating in any physical activity but is specific to the profession of dance. Body dissatisfaction and disordered eating is a result of the profession and not due to being highly physically active. This is important to distinguish, as patients who are in certain lines of work are at a much higher risk of developing AN and warning signs should be closely monitored. This study also found that girls who enrolled in a non-professional ballet school also showed poor body image and restricted their eating in order achieve the "perfect silhouette" (Ravaldi et al. 2003). Therefore, the risk of developing AN increase regardless of the level of competition and even at a recreational level, dancers are vulnerable to pressure to conform to an unhealthy standard.

In 2007, two Brazilian models died as a result of AN. This tragedy demonstrates the extreme pressure put upon this profession to remain thin at any cost. In response, a major fashion show in Spain banned extremely thin models from the catwalk (Moya, Caludino, & Furth, 2007). This response, while one small effort, shows the impact and necessity of many groups and organizations coming together to stop the perpetuation of unhealthy beauty standards. The most desirable outcome would be that many disciplines and many societal segments

collaborate efforts to establish protections for young people who are in particularly vulnerable professions.

Physical Activity and the Drive to Exercise

AN is associated with excessive exercise. In fact, 80% of patients that suffer from an eating disorder report a strong desire to be physically active (Keyes et al., 2015). This involves deliberate workouts, such as going to the gym, and other forms of body movements like fidgeting as a means to lose weight. High levels of the drive for exercise has been associated with a poor prognosis and treatment dropout. Exercise is also utilized as a form of emotional regulation and helps to produce a calming state in women with AN who also struggle with affective disorders (Bratland-Sanda et al., 2010). Physical activity for women with AN is motivated by obtaining a specific figure or appearance more so than enjoyment. Keyes et al. (2015) found that the group with AN had a considerably higher drive to exercise than the healthy controls and the anxiety group. This suggests that the drive to exercise in AN is more associated with eating disorder pathology than anxiety. Sternheim, Danner, Adan, and Elburg (2015) found that higher levels of drive for exercise was associated with more severe AN pathology. Clinicians should be mindful of this, as drive for exercise may indicate the severity of the disorder and should be included in assessment considerations.

A biological interaction exists between increased physical activity and decreased food intake (Epling & Pierce, 1988). Strenuous exercise reduces the value of food and therefore decreases the reinforcement that eating food provides. Additionally, a decrease in eating increases the drive to exercise, which then further suppresses appetite. This cycle is resistant to change once started and may have an evolutionary advantage. Physical activity is beneficial in

times of food scarcity, as finding and hunting food requires exercise. Understanding biological interactions between physical exercise and food intake may be useful in treatment considerations, as the exercise may be a barrier to food enjoyment and suppresses appetite. Excessive exercise is also associated with higher levels of psychological distress and a reduction in quality of life (Young et al., 2018). Therefore, treatment which addresses physical activity may reduce the burden of illness from AN and may improve the level of engagement in treatment.

Currently, exercise is not a recognized treatment for AN (Hausenblas, Cook, & Chittester, 2008). Zunker, Mitchell, and Wonderlich (2011) conducted a literature review to identify exercise interventions and review recommended treatment strategies for those with a high drive for exercise. They found that very few studies explored this issue and their literature review suggested a need to develop future research in this area and standardized guidelines should be developed in order to treat excessive exercisers with AN.

One study examined novel treatment for AN to address the drive for exercise. Paslakis et al. (2017) utilized virtual reality jogging as a form of exposure treatment with AN patients. They found that habituation to physical activity was achieved and those who participated in the virtual reality treatment had less urges to engage in physical activity. Although this pilot study had a small sample size, it provides initial support for the feasibility and benefits of utilizing virtual reality to target the urge for a patient with AN to be physically active. This type of research is essential for clinicians to have evidence-based practices in how to treat various symptomology of AN and the importance exercise plays in the maintenance of this disorder.

Another study that explores innovative ways to address the drive for activity in AN was done by Hall, Ofei-Tenkorang, Machan, and Gordon (2016). They explored how yoga may have a positive impact on how women with eating disorders viewed their body. They found that yoga may be an effective add-on treatment for addressing depression, anxiety and weight gain fears. This study aimed to offer a physical exercise option that would not have risks of weight loss or medical decompensation. The women in this study participated in physical activity but did not experience weight loss suggesting that yoga may be a safe way to engage in physical activity. New and innovate treatment approaches should continue as outcome measures of existing treatment are less than ideal.

Existing Treatment

Cognitive-behavioral therapy (CBT) is the predominant treatment for AN and is widely applied in both inpatient and outpatient settings (Halmi, 2005). Garner and Bemis (1982) developed CBT for AN patients which was later published as a manual. This orientation focuses on how thoughts, feelings and behaviors are related and impact one another. Patients are encouraged to monitor their eating behaviors, along with the accompanying thoughts and emotions related to eating. Once a patient can identify and monitor their internal states the focus shifts to trying to restructure maladaptive thinking patterns. Cognitive restructuring involves challenging and modifying believes the patient may have about themselves, others and the world. Problem solving skills are also addressed, as patients are asked to think about potential solutions and brainstorm coping methods to handle the distress the may experience during the recovery process and eventual weight gain. Behaviorally, a patients weight is monitored closely and positive reinforcement strategies are employed to enhance motivation for weight gain. Although

CBT continues to be heavily utilized as the treatment for AN, studies have shown mixed results in terms of outcomes. Studies have found that CBT is superior compared to nutritional counseling alone, demonstrating the need for psychological intervention (Pike et al., 2003; as cited in Halmi, 2005).

While studies like the ones above suggest that CBT is an effective treatment for AN, it is important to note that other studies that have compared CBT to other treatment modalities were unable to determine clinical superiority of any one treatment (Grange, 2016; Zipfel et al, 2009). Zipfel et al.'s (2009) study randomized 242 patients with AN into three treatment modalities; CBT, focal psychodynamic therapy, and treatment as usual and found no statistical difference in outcomes. Studies like this suggest that treatment of AN should not be viewed as a one size fits all and therefore there is a need to create individualized treatment modalities for those patients that may not respond to CBT or other well test psychotherapies.

A number of authors have shown the benefit of a variety of approaches to treatment as a response to patient needs and have designed programs to accomplish this. For example, Cognitive Remediation Therapy (CRT), as used by several of the studies reviewed, increased patient flexibility of thinking and increased their use of gistful information-processing as opposed to detail-orientated processing. Because it does not focus on weight gain in its initial stages, CRT is ideal for patients who have low motivation and who have higher body mass at the start of treatment (Lock et al., 2013). Such treatment strategies as CRT contrast with other treatment modalities, which focuses on re-feeding and weight gain early in the treatment process, and therefore treats the negative impacts of starvation on cognitive brain function (Couturier et al., 2013). Group therapy, on the other hand, might be ideal for those who have feelings of

isolation in association with their disorder and need healthy social interactions (Goldstein et al. (2011). These examples illustrate the benefits of the creation of new and innovative treatment modalities that enhance a client's chance of finding the right fit for them.

Medications should be considered if a patient is not responding to therapy alone (Halmi, 2005). Cyproheptadine (Periactin) has been shown to be effective with the initiation of weight gain and reduction in depressive symptoms (Halmi et al., 1986; as cited in Halmi, 2005). Periactin is traditionally used to treat allergies and its mechanism of action is to block histamine from binding to cells. However, one of its side effects is an increase in appetite. Because of this side-effect, it is also used to treat those who are suffering from AN as a way to promote eating.

Prozac has also been utilized in the treatment of AN. There is some evidence that it may help prevent relapse by targeting compulsive eating behaviors that are seen in patients with AN. (Kaye et al., 1991; as cited in Halmi, 2005). While this is promising, it is important to know that this medication has not been effective in treating low-weight anorectics. Prozac and other antidepressants may be helpful in treating depression and anxiety disorder, which patients with AN commonly also suffer. By stabilizing an individual's mood, it may help to achieve other treatment goals. Medication is not a first line of defense for the treatment of AN, and therefore should be considered only after other forms of treatment have been tried.

Recently, non-invasive neuromodulation has shown promise in reducing AN symptomology (Costanzo et al., 2018). Neuromodulation is the stimulation or inhibition of neural activity. Costanzo et al. used transcranial direct current stimulation (tDCS) on left anodal/right cathodal prefrontal cortex to establish inter-hemispheric balance. The brain areas stimulated are involved in the mesocortical dopaminergic pathways, which are the pathways that

involve the promotion of food intake. This study utilized a control group, who received treatment as usual and did not receive tDCS stimulation. They found that BMI increased only in the tDCS group, even at a 1 month follow up. Brain based treatment is a relatively recent technique, and psychological therapies are widely considered the treatment of choice for AN. The possibility of enhancing the efficacy of psychological treatment by incorporating brain-based treatments is an exciting prospect and one that deserves future attention and research.

Why Utilize Narrative Therapy?

As mentioned earlier, no one treatment modality has been "crowned" to be the most effective and the literature cautions against using a one size fits all approach. Therefore, it is important to create different approaches which may be effective to treat those who have not responded to more traditional treatment programs. The goal of this paper is to create an effective treatment modality to use with adult women suffering from AN. I believe that grounding treatment in a narrative therapy orientation will provide strengths that other treatments do not offer. The process of externalization would be extremely beneficial, particularly because those suffering with AN see their disorder as a part of their identity (Gorse et al., 2013). Externalizing the problem as a form of treatment was supported and discussed in the research literature reviewed (Couturier et al., 2013; Gullikesen et al., 2012). The main benefit of externalizing conversations is that the person can see themselves as separate from the problem. People often find a great relief in doing this as it opens space for them to work cooperatively to revise their relationship with the problem. Problems also seem less fixed and restricting and their skills become more visible. Externalizing conversations reduce guilt and blame; however, they also leave room for responsibility. Separating the disorder from the person would therefore help the

patients see themselves in a new and healthier way. The ambivalence felt towards recovery may then be reduced and this would make room for the patient to create an alternative narrative. This may also be a way to reduce the feeling of losing one's identity, once they recover. "The goal of narrative therapy is to get clients to re-story their lives by taking notice of alternative plots to problematic thoughts, feelings, or situations" (Morgan, 2000, p.5). This process allows clients to view themselves in a different light and further separate their identities from the problem.

Another reason I have chosen narrative therapy with which to base this manual on is its ability to address core issues of AN. It appears from the research that focus on psychological issues of this disorder must be as much part of the treatment strategy as weight gain. Addressing psychological issues is very important in dealing with the root cause of the disorder, and therefore in clinical practice, this should remain a focal point in the steps to recovery. Eating pathology can arise from various sources and, once again, individualized treatment plans are needed to address the very unique lived experiences of each client. Narrative therapy provides a collaborative space in which to explore these unique lived experiences and therefore clients will not feel "boxed in" or labelled.

Narrative therapy will enhance motivation for treatment and motivation is vital when working with this population. In a study by Wade, Frayne, Edwards, Robertson and Gilcrist (2009) motivation was found to be important in the prediction of change in eating pathology, and it was noted that future research and practices should focus on increasing the amount of motivation in patients by implementing a large amount motivational interviewing into the treatment process. If outpatient programs are to be effective in the treatment of AN,

motivational techniques must be incorporated. This manual is created with ambivalence in mind. It embraces ambivalence rather than pushing past it, allowing space for the client to express what they may like about AN. By giving AN a "voice" narrative therapy explores why a particular client may be reluctant to change. Both therapist and client acknowledge the reluctance to change and therefore the client is free to let go of the feeling of "fighting" the therapist. Motivation for change will come from within the client exploration of their narrative rather than from pre-determined labels that tell them they "should" want to change. According to Gulliksen (2012) patients preferred to be referred to a therapist who was both accepting and challenging. This can be very difficult to balance as a practitioner and will be one of the most difficult aspects of working with this population. Gulliksen (2012) further states that maintaining rapport and an empathic stance can be challenging for clinicians and that previous research has shown that there is a tendency for health professionals to hold a negative attitude towards AN patients.

External support is also highlighted in the current research about treatment of AN. According to Miller, Duncan and Hubble (1997) "extra therapeutic factors" (aspects of life outside counseling) have the largest impact on treatment outcomes. This is an important factor to keep in mind as a clinician, and I believe it is important to include loved ones in the treatment process. This manual is designed with that in mind and is an outpatient treatment program. Therefore, it has the ability to keep clients at home in their communities and provide a great advantage in terms of this external support aspect. As an example of the power of external support, group therapy was shown to allow for positive interactions and alleviate feelings of isolation (Whitney, Easter, & Tchanturia, 2008). In narrative practice, outsider witnesses are encouraged to participate at the end of treatment and are invited by those who have recovered

(Morgan, 2000). Alleviating the sense of isolation that comes with suffering from an eating disorder by accentuating support structures therefore is an important key to full recovery.

Treatment Considerations

Several treatment considerations found in the literature have informed the creation of this manual. One such article was by Jarman, Smith, and Walsh (1997). They considered the importance of therapists' understandings of AN, with a particular focus on the construct of control and the different meanings this construct may elicit. Given the client with anorexia's intense desire for control, power struggles may emerge between the client with anorexia and the clinician during treatment. This study illuminated the multiplicity of definitions and meanings associated with control that are present during the treatment process. Various conceptions of desire for control were revealed, some referring to the anorexic person's relationship with the 'self' and some to interactions between the person and others. The findings from this study suggest a depth and complexity to this construct and it therefore seems important that clinicians reflect on the meanings they bring to the treatment context and consider how their understandings and experiences affect the treatment of their clients (Jarman et al., 1997). This manual takes into consideration the high potential for conflict with clients and its aim is to reduce or eliminate this power struggle. By utilizing a narrative therapy framework, the therapist sees the client as the expert and themselves as an ally. While the goal of therapy still remains the same as other treatment approaches (to treat symptoms of AN), it does so with a softer touch which will lead to less resistance and ultimately less drop outs.

Another treatment consideration is the importance of the therapeutic alliance. While not specific to the treatment of AN, as therapeutic alliance is seen as an important part of any

therapeutic environment, it is especially relative to this population due to the possibility of having negative experiences with previous medical professionals and their loved ones. A study by Oyer, O'Halloran and Christoe-Frazier (2016) explored the working alliance that was formed during treatment and how the relationship was challenged. Participants in this phenomenological study included eight clients with anorexia nervosa and seven therapists, and sought to understand the factors that both assisted and interfered with the therapeutic alliance during treatment. Semi-structured interviews were conducted and various themes emerged from the data. The data indicated that a positive alliance was formed when the following factors were present; unconditional positive regard and basic counseling skills, identifying and highlighting strengths, individualizing treatment and having a knowledgably therapist. Furthermore, the ability of the therapist to create a safe space, be aware of their personal limitations and knowing when to consult with others were found to be helpful factors. On the other hand, unhelpful factors included a lack of attention or understanding of specific needs, over emphasizing the importance of weight gain, biases leading to feelings of judgement and lack of flexibility in treatment delivery. They also determined that when therapists were truthful about their lack of knowledge in specific areas (e.g. nutrition) trust was built and this enhanced the overall quality of the relationship.

Another consideration in the creation of this manual, and found in the literature, is that there is a lag between recent research findings and their application. One example of such lag is Family-based treatment (FBT) which involves the patient's family as a primary support to assist in the goals of therapy. Despite evidence of its effectiveness, this form of treatment is underutilized by therapists and a study by Couturier et al., (2013) aimed to explore why this may

be. The findings suggested that the time commitment required to implement FBT was seen as a barrier to its use in clinical practice. Other barriers mentioned were the need for parental consistency, inadequate attention to comorbid symptoms, the lack of family meals in a real-world setting, and getting siblings involvement. Another drawback mentioned was that FBT did not require dieticians to be involved in the therapeutic process and only 6 of 40 therapists felt their patients did not require a dietician. Five therapists stated that a dietician was an essential component to the treatment of eating disorders and felt that without a dietician on their team they would be practicing outside of their scope. Therapists also stated that director/administrator support was very important and was needed in order to adopt the FBT model in their workplace. Participants expressed that their colleagues are heavily influenced by the model adopted by directors and therefore would want adoption of FBT to be top down. All of the participants reported family-specific factors that influenced their ability to implement FBT such as parental motivation to participate, and their understanding of the severity of an eating disorder diagnosis. Approximately 68% of the participants reported that the complexity of anorexia nervosa makes it difficult to commit to any one specific evidence-based practice (Couturier et al., 2013). It is therefore important to not only continue the research and creation of effective AN treatment modalities, but also to research which factors are seen as barriers to implementation. This literature review demonstrates the importance of understanding clinician's views and perspectives, and therefore this manual was created with ease of implementation in mind in order to increase the chances of implementation.

Stigma of AN

Stigma around mental health is a primary barrier for treatment and therefore should be

addressed. AN is particularly stigmatized in society due to a perception of self-control required to starve oneself. Due to this misconception of self-control, individuals with AN may be blamed for their illness. A study by Stewart, Keel, and Schiavo (2006) compared the perceptions held about a person suffering from AN, a healthy person and a person with another mental illness. They found that negative perceptions were held about those with AN, which was not the case for healthy controls. Furthermore, individuals with AN elicited more negative characterizations than even individuals with schizophrenia. Specifically, those with schizophrenia elicited themes of fear as their illness was seen as beyond their control while those with AN elicited a theme of blame. Schizophrenia was also seen as having more biological factors in the development of the illness and therefore protected them from being seen as responsible for their illness. Additionally, the fact that AN primarily affects young women may impact people's perception of the severity of the illness (Stewart et al., 2006). If AN is viewed as a less serious mental illness than schizophrenia or affective disorders it may garner less empathy for those suffering from it. Another reason for the heightened stigma of AN discussed in the article was that pharmacotherapy for AN is limited, and therefore AN is not thought of as having a biological etiology. They utilize Viagra as a comparison, as this pill took away some of the stigma related to erectile dysfunction. It therefore seems important to educate people on the biological factors in the etiology of AN in order to reduce stigma felt about the illness. However, it is also important to educate people about psychosocial risk factors and that they are not "controllable" and may be just as difficult to modify as biological factors.

A study by Mond, Robertson-Smith, and Vetere (2006) examined the specific negative attitudes that college students had of AN. The women in their study read a vignette that

described a fictional 15-year-old female (Lucy) meeting diagnostic criteria for AN. They had negative views on items that pertained to self-centeredness and social distance. A majority (63%) reported that they would be reluctant to interview her for a job. A third reported that they would find her behavior rather irritating. These attitudes suggest that a majority of participants would want some social distance from those suffering with AN. Many participants in the study believed that Lucy wanted attention and that her "main problem" was low self-esteem. If a participant had these attitudes, they tended to perceive AN as less severe than those who did not hold these beliefs. Therefore, the perception that eating disorders are a result of low self-esteem may lead to thinking that AN is not a mental health problem. This view is extremely dangerous, and if internalized by those suffering with the disorder, may lead to patients not seeing psychological treatment as warranted or necessary. Additionally, the study found that the participants that recognized the severity of AN tended to attribute desirable properties to it. This indicates the level of ambivalence women may feel towards AN, as they are not immune to the culture of thin that exists in Western society. The desire to be thin is found in the general public and therefore patients with AN may be viewed in more positive ways than other mental illnesses. They also found that women in the study tended to view the prognosis of AN as good and were more optimistic of treatment than both mental health professionals and individuals affected. This is contrary to literature on AN and shows the lack of information that the general public has about AN. This indicates that educational programs that provide information on AN and its prognosis may help to reduce stigma and help remove barriers for treatment for those suffering from this disorder.

Bannatyne and Stapleton (2015) developed and evaluated the effectiveness of two

educational programs for medical students with the goal of reducing stigma of AN. First year medical students have greater negative biases when treating patients with AN compared to patients with other illnesses such as diabetes (Brotman, Stern, & Herzog, 1984). Physicians have also been found to communicate negative messages to patients suffering from AN indicating that their time is valuable and should be spent with those who are "really sick" or "more deserving" (Happell, 2005). Brotman et al. (1984) found that medical students participating in either educational program reduced their negative beliefs about patients with AN when compared to the control group (no education provided). Specifically, they had lower levels of blame and attributed less responsibility to sufferers. There was no significant difference between the two educational programs immediately after the training (one offering a traditional multifactorial intervention and one offering a biogenetic intervention). The biogenetic intervention focused more on the biological and genetic factors associated in the etiology of AN. They did find a difference between the two programs at an 8-week follow-up. The intervention effects in the biogenetic group were maintained over time, which was only partially supported in the multifactorial group. This suggests that knowledge of the biological and genetic factors increases the likelihood of long-lasting perspective changes and therefore the best way to reduce current stigma levels.

A study by Doley et al., (2017) found that the most effective way to reduce AN stigma was a combination of education and contact with anorexic individuals. While this is promising research, it is important to implement resources to train professionals who may work with anorexic patients. Stigma reduction may help those suffering from this illness to seek treatment while also reducing the amount of shame they may feel about themselves. Additionally, stigma

reduction would assist professionals to build a therapeutic alliance, which is essential to improve outcomes and increase recovery odds.

Internalization of stigma can cause damage to those suffering from AN. Internalization of stigma is a process where stigmatizing attitudes that are perpetrated by others has gradually become a part of one's own attitude. This can lead to feeling shameful about oneself and feeling as if they are to blame for their illness. This destructive belief system can have many implications in the treatment process. Griffiths, Mond, Murray, Thornton and Touyz (2015) examined stigma resistance in those suffering from an eating disorders. They defined stigma resistance as the capacity to remain unaffected by the stigma of mental illness. They found that 26% of those diagnosed with AN had low to minimal stigma resistance. In contrast, only 5% of people who were in recovery of AN had low to minimal stigma resistance suggesting that stigma resistance may play a role in the recovery process. Additionally, stigma resistance was significantly associated with less severity of AN symptomology, less depressive symptoms and were more open to seeking treatment. This study shows that the impact that stigma can have an affect not only on treatment outcomes but also on the likelihood that someone will even seek out treatment. This helps to inform clinicians about the potential barrier to treatment that stigma can have on those suffering from AN and therefore the importance of assessing and addressing stigma resistance in patients. This study's findings may suggest that stigma resistance is strengthened by treatment. Psychotherapy may provide patients with cognitive restructuring tools that allow patients to develop resistance. This has broader implications than just the recovery of AN and may lead to a heightened sense of confidence. By strengthening one's ability to block negative messages from becoming internalized, it allows a person to implement

and develop their own standards and judgements. If these standards are formed with self-compassion, it is likely to be positive and assist in the development of a positive self-esteem and self-image.

Biological Aspects of AN

Starvation related complications are important for a treating clinician to have knowledge of. It can have an impact on the treatment course, as some of these complications effect cognition, mood, and sleep. These factors can make treatment difficult and introduce barriers to the treatment plan. Assessment of and flexibility to starvation related complications is therefore essential.

Medical complications can include cardiovascular changes. Starvation leads to both bradycardia (heart rate less then 60 beats per minute) and hypotension (Kaplan & Woodside, 1987). Hypotension is a medical term for low blood pressure. This can result in patients feeling temporary dizziness when they move from a sitting to a standing position and may even result in black-outs. Blacking out may cause patients to sustain injuries or embarrassment if they lose consciousness in public places, therefore increasing isolation or shame they feel about suffering from AN. Amenorrhea happens when a female patient loses more than 15% of their normal body weight. Underweight patients also show a reduced body temperature and feel cold easily. They may also feel generalized muscular weakness due to decreased levels of potassium (Kaplan & Woodside, 1987). Reductions in potassium are particularly pronounced in patients who use diuretics in an effort to lose weight. It is therefore important for clinicians to know and understand the different methods patients use to lose weight and the potential health implications

of these methods. Building a trusting relationship will enhance open and honest communication and increase the likelihood of clinicians obtaining this information.

In addition to medical complications due to starvation, there are also cognitive and behavioral effects. Starved individuals show impairments in concentration and alertness (Kaplan & Woodside, 1987). Patients with AN may be distractible, apathetic and lethargic. Loss of libido is also common in severely underweight patients. Starvation may also impact sleep quality. Understanding that personality changes can result from starvation is important, as these changes can mimic other psychiatric illnesses and result in misdiagnosis. It can also help clinicians understand the link between weight gain and improvements in other areas. Patients who are severely underweight may not be as "psychologically available" and the potential benefits from psychological interventions may be hampered.

Another cognitive impairment often found in patients suffering from AN is set-shifting (Holliday, Tchanturia, Landau, Collier & Treasure, 2005). *Set shifting* is the ability to switch between tasks. However, this may not strictly be the result of starvation, as difficulties in set-shifting were found in woman even after recovery. This indicates that this may be an endophenotypic trait, or a genetic predisposition to the development of AN. A biological marker is defined by several factors: it is state-independent; it leads to illness; and is found at a higher rate among family members than those who are unrelated (Holliday et. al, 2005). A study by Tchanturia, Morris, Surguladze, and Treasure (2002) found that set-shifting difficulties were found at every stage of the illness, including recovery, which satisfies the first requirement. The study by Holliday et. al (2005) found that unaffected first-degree relatives (sisters) shared this set-shifting impairment, indicating that this is likely a biological marker for AN. While there are

still many unknowns in the biological etiology of AN, this study demonstrates that genetics are at least in part responsible for the development of AN and as discussed above, disorders with biological etiologist tend to invoke less stigma and less internalized blame.

Twin studies have suggested that genetic factors contribute 60% to the risk of developing AN (Bulik, Suillivan, Tozzi, Furberg, Lichtenstein, & Pedersen, 2006). However, the exact gene loci involved is still unknown. A study by Karwautz et al. (2011) found a significant effect of the 5-HTTLPR genotype on the risk of AN. The 5-HTTLPR is the gene responsible for the serotonin transporter. However, it is likely that there are gene-environment interactions, indicating that someone with this genetic trait may be more vulnerable to adverse life events, which may lead to the development of psychiatric disorders such as AN. While scientists are trying to understand the specific brain regions that may predispose someone to AN, it is important for clinicians to recognize that environmental influences contribute to the "switching on" of these genetic vulnerabilities.

Inpatient versus Outpatient

The question of whether outpatient treatment is as effective as inpatient treatment is another area that was discussed in the literature. As this manual is created as an outpatient program, it is important to understand the potential implications of providing treatment in a less structured environment than an inpatient program. While the answer is not clear cut, the following themes were identified and discussed to help understand the potential strengths outpatient programs.

Outpatient Program Ability to Address Patient Ambivalence

One of the major findings of this literature review is that patient ambivalence to their illness and treatment is common. Ambivalence in AN patients is described as the state of having mixed feelings or contradictory ideas about their disorder. This theme implies that AN patients are often conflicted about their recovery, because a part of them wants to get better but another part wants to remain thin and have control over their eating patterns. Such patient ambivalence seems to be expressed in three ways according to the literature reviewed: low or widely variable levels of motivation by the patients to recover; by patients being assessed at a low stage of readiness for changing their condition; and/or as a fear by the patients of loss of identity during treatment (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013; Paulson-Karlsson, & Nevonen, 2012; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). In fact, patient ambivalence was seen as such an important obstacle to treatment that all of the new outpatient programs described in these articles took some measures to address this condition during treatment (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). Therefore, outpatient programs ability to address ambivalence is a key factor when determining effectiveness and its ability to supplement inpatient programs, as outpatient programs rely on patient participation and willingness for treatment.

As one expression of this ambivalence, motivation of AN patients to recover is often described as low or that it varies widely and frequently during treatment. Such variability in motivation due to the patient's ambivalence to their disorder prolongs treatment or delays recovery. Lack of motivation can lead patients to not follow treatment suggestions and/or

dropping out of treatment entirely. Patients who are not motivated to recover can also feel overwhelmed and discouraged by previous failed attempts in treatment and have "lost hope" that recovery is possible. In order to ensure that the patient is making good progress toward recovery, the authors note that motivation levels must remain constantly high (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). Furthermore, it is essential that treatment be provided at the "right time;" that is, when patients are receptive to treatment and therefore motivated to recover (Whitney, Easter and Tchanturia, 2008). Parent motivation is also an important factor when treating adolescents with AN, and the presence of ambivalence to the disorder can also jeopardize recovery if present in the immediate support network of the patient (Couturier, 2013). This demonstrates that motivation and attitudes of patients towards treatment can stem from views held by those close to them. This can have a large impact on their views regarding the severity of their illness, if they feel they need treatment, if they view their eating patterns as unhealthy, and the perception of how likely it is that treatment will work for them. These perceptions can have a drastic influence on their motivation to recover.

The degree of motivation can also impact choice of treatment program. Patients who feel ready for change (motivated to change) feel that an outpatient program can meet their needs, and those who have a high degree of ambivalence (low motivation for change) often insist that they be placed in inpatient treatment programs (Paulson-Karlsson, & Nevonen, 2012). This seems to happen because the outpatient program requires more independent commitment from the patient for completing treatment steps. Also, there is increased opportunity for the patient to decide to discontinue treatment in an outpatient program. With the observed low drop-out rates in these

outpatient studies, this would seem to indicate that higher motivation levels are present in patients who request such programs. It also appears that motivation to recover may fluctuate over time and with weight gains or losses, making motivation a continually changing element in recovery and not a static trait or attitude (Paulson-Karlsson, & Nevonen, 2012). When determining if an initial positive attitude toward attaining treatment and an intention to recover is present, however, the studies found that maintenance of such positive motivation (reduction or removal of ambivalence) is of great importance, especially after an initial weight gain is achieved (Paulson-Karlsson & Nevonen, 2012).

Patient ambivalence to treatment and recovery was also expressed in the findings as a lack of readiness-for-change, and so ambivalence expressed in this way was seen as a large barrier to recovery. Readiness for change is linked to ambivalence because a patient must be mentally and physically prepared for the road to recovery. For example, if a patient is too weak or medically unstable, an intensive introspective treatment program would not be successful as the patient is not in the suitable mental state. A patient who does not view him/herself as ill and is forced into treatment will not respond well due to their lack of readiness for change. Treatment at this stage would focus on changing their thought patterns around their illness and meet them at their current level instead of focusing on weight gain. Researchers reported that readiness-for-change can be addressed and reduced while patients are being treated in an outpatient program. Using several assessment tools, they found higher values with respect to the readiness-for-change measure when the patient responded well to treatment (Goldstein et. al., 2011; Wade, Treasure & Schmidt, 2011). As an example, in one study, 73% of the patients started the treatment program at the "preparation" or lower level of readiness-for-change;

however, at post-treatment, 62% were classified as falling within “action” or “maintenance” or higher stages of readiness-for-change (Goldstein et. al., 2011). This demonstrates that outpatient programs can supplement inpatient programs with respect to addressing ambivalence; a key barrier to treatment success.

Finally, according to the reviewed authors, it appears that patients with AN often see their disorder as a part of their identity (Gorse et al., 2013; Gulliksen et al., 2012; Paulson-Karlsson, & Nevonen, 2012). Ambivalence to treatment and recovery is often expressed when such loss of identity is seen as at risk by the patient. Therefore, something as basic as weight gain leads the patients to feel a loss of their identity and therefore triggers ambivalence to recovery or results in a sudden refusal of treatment. In the qualitative study conducted by Gorse et al. (2013) recovery was seen by patients as an unknown - that it could result in the patients abandoning a part of themselves. Furthermore, a qualitative study by Paulson-Karlsson and Nevonen (2012), to determine treatment expectations of a group of women, found that these participants wanted to see themselves as different than their disorder and wanted to be seen by others in this way as well, an indication that identity served as an important factor in treatment and recovery.

Both outpatient and inpatient treatment programs struggle with the issue of fear of recovery and loss of identity, and there is no clear evidence that one modality is better than the other at addressing these ambivalence factors. While inpatient programs offer a more intensive and intrusive treatment program, these fears, if not addressed will impact response to treatment in the same capacity as patients in a less intrusive outpatient treatment program. The issue then becomes less about treatment modality (inpatient vs. outpatient) and more about the responsiveness of therapists to address and combat ambivalence.

Outpatient Program Ability to Address Core Psychopathology of AN

One of the major findings in the reviewed literature was that outpatient programs have the ability to address AN core psychopathology. This is because these programs are able to achieve changes in cognitions, attitudes and belief systems especially in regard to healthy eating patterns. In fact, outpatient programs seem to recognize the need to address *all* aspects of AN core psychopathology, and not just weight gain, seen by most authors as a necessary factor in recovery (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). Three eating disorder traits of AN psychopathology cited most frequently in the current research are: drive for thinness, body dissatisfaction, and perfectionism. These traits are the ones that were highlighted in the cited articles to show treatment successes; that is, to determine if recovery was achieved and relapse of this disorder prevented.

To address the trait of perfectionism as one psychopathology addressed by outpatient treatment, these studies encouraged patients to think in different and creative ways, to break rigid behavior patterns, and to take risks to reduce a tendency toward this trait. Such therapies as CRT (Cognition Remediation Therapy) were shown to be effective (Whitney, Easter & Tchanturia, 2008) and also helped patients to reduce perfectionism by getting them to think more broadly and creatively, and to look at multiple points of view (for example, Whitney et al., 2008). The elimination of or reduction in such rigid thought patterns reduced perfectionist tendencies, especially related to establishing healthy eating (reducing obsessional thoughts about food, calorie-counting, and going to excessive lengths to achieve their "ideal" weight) and therefore aided recovery.

Outpatient treatment also had an impact on the psychopathology trait of "Drive for Thinness" (measured by the Eating Disorder Inventory), and a reduction in the drive for thinness reflected behavioral and attitudinal change achieved during the outpatient treatment described by some studies (for example, Goldstein et al., 2011). Although reported by the authors as trends only because the study had no long-term follow up components, these authors did suggest that such reductions could be maintained based on a 6-month follow-up questionnaire which was administered (Goldstein et. al., 2011). A reduction in the scale for "Drive for Thinness" was, in fact, present in those patients that responded well to treatment (for example, Schnicker, Hiller, & Legenbauer, 2013). In fact, a dropout group of patients showed a higher value in the scale for "Drive for Thinness" (had a high drive for thinness) than a completer group. The authors speculated that this occurred due to a drop-out (non-completer) patient's decision to leave therapy after the first weight gain, since this gain caused them to deviate from their "ideal of thinness" standard (Schnicker et al. 2013).

The trait of 'body dissatisfaction,' as one of the core psychopathologies of AN, is the most difficult to address because, in my opinion, this trait relates to standards which may vary from group to group and by gender. Reduction in the 'body dissatisfaction' scale (Eating Disorder Inventory) has yet to be realized and one set of authors suggested that future programs must tailor their treatment to address this issue more directly (Goldstein et al., 2011). Program treatment goals to-date have been limited to 'acceptance of their body' rather than the broader definition of 'body dissatisfaction' which carries a wider concept than 'ideal' weight (Paulson-Karlsson, & Nevonen, 2012).

Outpatient Ability to Meet Patient Needs

One of the major findings of this literature review was that patient needs vary. Patient needs may vary due to many factors: e.g., age, severity of illness, support system, and the trait psychopathologies discussed in the previous section. It also appears that the availability of different types of individualized and specialized outpatient programs might work to respond to patient needs and so will reduce the number of patients who do not respond to therapy. In fact, patients often request a specific treatment modality (Paulson-Karlsson & Nevonen, 2012). I interpreted this as a strong indication that each patient has very different needs and different types of therapy will benefit some and not others. Furthermore, therapists describe their patients as having very different needs when entering treatment and clearly believe that adopting a "one size fits all" treatment philosophy would not benefit their clients (Couturier et al., 2013).

A number of authors have shown the benefit of a variety of approaches to treatment as a response to patient needs and have designed programs to accomplish this. For example, Cognitive Remediation Therapy (CRT), as used by several of the studies reviewed, increased patient flexibility of thinking and increased their use of gistful information-processing as opposed to detail-orientated processing. Because it does not focus on weight gain in its initial stages, CRT is ideal for patients who have low motivation and who have higher body mass at the start of treatment (Lock et al., 2013). Such treatment strategies as CRT contrast with family-based treatment, which focuses on re-feeding and weight gain early in the treatment process, and therefore treats the negative impacts of starvation on cognitive brain function (Couturier et al., 2013). Group therapy, on the other hand, might be ideal for those who have feelings of isolation in association with their disorder and need healthy social interactions (Goldstein et al. (2011).

Importance of External Supports in Treatment and Recovery

One of the major findings of this review was that external supports are vital to treatment of and recovery from AN. AN is frequently described as a very lonely illness, with patients often suffering from isolation from supports. Because patients often describe their disease as cutting themselves off from their family, friends and work, making relationships with others very difficult, a common advantage of outpatient programs is their ability to keep patients in their communities, surrounded by their support systems and loved ones (Gorse et al., 2013). In fact, it was noted that, given the isolating nature of this disorder, all of the outpatient treatment programs reviewed in these articles took measures to reduce this feeling of isolation and to value each patient's support systems. As evidence of this, in one study, parents, as one type of an external support, played a large role in the treatment of adolescents. The direct involvement of parents in the re-feeding process in this study was very important to recovery, and strong involvement of the family was seen as an advantage of using family-based therapy (Couturier et al., 2013). Group therapy, used in another study, also allowed for the building of relationships and reduced isolation, where group meal outings allowed for positive social interaction. In this program, parents were also supported by offering them parent-only groups and weekly joint psychology groups, to support improved communication between parent and child (Goldstein et al., 2011). As another specific example of the finding that external supports are important to treatment and recovery, one study used interventions intended to increase social competence in order to strengthen relationships with patient external supports, and patients were more likely to complete treatment if they were strongly tied to such external supports as employment or a live-in partner (Schnicker et al., 2011).

In summary, findings show that outpatient programs can result in increased patient readiness-for-change, better response to patient needs, program ability to address core psychopathology traits of this disorder and provide improved patient external supports to increase effectiveness of treatment. It is also clear from the evidence presented in these studies that the trend toward the use of specialized outpatient programs, and thereby better responding to patient needs, presents much promise as a useful supplement to inpatient programs.

Future Research

It is clear, after a review of the literature, that future studies are vital in the understanding and development of best practices when treating patients suffering from AN. Several specific suggestions for future research followed from the findings of this literature review and are described below, along with possible research questions, which could be addressed.

Motivation and Readiness for Change

In order to determine the efficacy of the treatment programs described in these articles, the focus on patient motivation and readiness-for-change should be more clearly defined. For instance, the addition of longitudinal studies focusing on motivation and readiness-for-change might provide a vehicle for determining how to prevent relapse of AN. Although some of the studies reviewed included follow-up interviews (Lock et al., 2013; Goldstein et al., 2011; Wade et al., 2011), none of the studies reviewed in these articles included adequate longitudinal study, with the longest follow-up period being one year beyond the initial data collection (Lock et al., 2013; Wade et al., 2011). Possible future research question: Does a treatment program that focuses on motivation and readiness-for-change prevent relapse of AN?

Patient Needs

A particular issue identified by Schnicker et al. (2013) concerns non-responders to therapy. The importance of identifying non-responders early in the course of treatment so that service providers can consider alternative treatment options is vital and responding to patient needs for treatment plays an important role in determining if alternate therapy was effective. Possible future research question: Can non-responders of one treatment modality respond well to another form of treatment?

Addressing Core *Psychopathology*

The trait of body dissatisfaction, while being an important determinant in this disorder, is ill defined and seems to depend on a wide variety of environmental and cultural factors. One study noted that their program treatment goal was limited to 'acceptance of their body' rather than the broader definition of 'body dissatisfaction' which can relate to more than 'ideal' weight (Paulson-Karlsson, & Nevonen, 2012). Addressing this core trait in terms of understanding how it can be expressed in those with AN might lead to more effective treatment. Possible future research question: What treatment modality has the largest impact on body dissatisfaction?

Ethical Considerations

One ethical consideration for those who are working with this population is the potential for AN to be lethal. AN is the deadliest psychiatric illness, although it is still rare and the vast majority of people suffering from AN will survive (Giordano, 2010). The case may be argued that, while AN may be lethal, it is distinguishable from other terminal illnesses. The main difference is that AN is reversible and the person suffering can get back to normal, or at least improve their quality of life. Therefore, if the right to die is ethically and legally contested

among terminally ill patients, it is expected to be even more controversial for AN suffers to have this right.

Clinician's must therefore grapple with the ethical decision of when involuntarily hospitalization is deemed necessary. Overriding a client's autonomy is never an easy decision and those who come to this decision may face feelings of betrayal from their clients. This certainly will have an impact on the therapeutic relationship and therefore can make the decision difficult.

A client's level of competency to make decisions about treatment refusal is an important factor. Tan, Steward, Fitzpatrick and Hope (2006) explored decision making capacity in women suffering from AN. They found that although the women had insight into their own difficulties, they did have concentration problems and muddled thinking. This led to difficulties in logical reasoning and belief in medical facts and the seriousness of their disorder. These deficits in thinking appear to impact belief systems not due to a lack of understanding, but in the weight that those facts are given when making a decision. For example, a woman may be able to acknowledge that she is underweight and is suffering health related complications as a result, however, will not use this information to inform decision making.

Therapists working with this population should be careful about self-disclosures. Disclosures that display belief in the thin ideal, support of certain diets and workout routines, or personal struggles with AN may be damaging to the recovery of the patient and blur the boundaries between patient and client. Therapists must be careful not to give advice drawn from societal demands or standards of female beauty. Fad diets are a large part of our culture, and therefore it may impede recovery to discuss these. Due to the western society places on

"thinness", clinicians will be fighting an uphill battle in terms of establishing definitions of beauty. Therapists must be sensitive to these beauty standards and be mindful of the detrimental impact innocent comments may have on their clients.

Competency may also be impacted by how compromised a client's sense of identity is (Tan, Steward, Fitzpatrick and Hope, 2006). If the client now sees the AN as their identity, treatment means becoming someone else. This makes an easy decision turn into an impossible one. Therefore, competency must be viewed in many ways, not just in a traditional intellectual sense and this can lead to confusion on the part of the clinician. It is cautioned that, during the use of this treatment manual, if clinicians consult with other professionals if in doubt and that the safety of the client is first and foremost throughout the 8 weeks of treatment.

CHAPTER III. NARRATIVE THERAPY MANUAL FOR AN

Rationale

There are several reasons for developing a treatment manual for the treatment of AN. Current understandings of the etiology of anorexia are still widely unknown and there is little empirical evidence to determine best treatment practices. In a literature review done by Meads, Gold and Burls (2001), just eight articles were found that provided information on whether inpatient treatment was more effective than outpatient care and of these eight, there was discrepancies in the data and therefore caution should be used when attempting to reach conclusions. This study highlights the need for continued creation of specialized treatment manuals that attempt to address some of the limitations found in current practice.

Another reason for developing this treatment manual is recognizing the importance of creation of outpatient programs. Due to the high costs and limited availability of inpatient treatment programs, clinicians are treating more patients on an outpatient basis and reserving inpatient facilities for those with the highest severity of symptoms. However, the idea that inpatient treatment is more effective than outpatient treatment still prevails. Due to the difficulty in researching anorexia nervosa treatments, answers are not clear. Therefore, it is important to continue to study this disorder and the effectiveness of different treatment modalities. Because patients often describe their disease as cutting themselves off from their family, friends and work, making relationships with others very difficult, a common advantage of outpatient programs is their ability to keep patients in their communities, surrounded by their support systems and loved ones (Gorse et al., 2013). In this treatment manual, the involvement of outside supports is considered essential in the therapeutic process.

Theoretical Foundations

Narrative therapy emphasizes the clients' view and perceptions to life events. (Walsh, 2010). A narrative is defined as the creation of meaning a person attaches to a specific event (Rosce, 2011). Narrative therapy at its core is non-judgemental, as it views problem behaviors as happening to the client and as separate from their identity (Walsh, 2010). In narrative therapy the client is assisted in the creation of new meaning to their experiences and thereby inventing a new and more positive view of themselves and the world around them (Walsh, 2010). By having someone with AN tell their story over time, it deepens their understanding of both themselves and the identified problem (Brosi & Rolling, 2010). Additionally, storytelling allows space to reconnect with or establish new emotional responses to their experiences (Brosi & Rolling, 2010).

A narrative therapist's intention is to have the client see themselves are separate from the problem they are experiencing. As discussed previously, clients with AN have difficulty in doing this. The therapist working from a narrative orientation uses language that allows for the separation of problem and identity. This language is referred to as externalization and this therapeutic intervention is the foundation of this orientation. These conversations will be very beneficial to those suffering from AN and the process of separating this disorder from the person is essential during the treatment process developed in this manual.

One of the assumptions of this manual and of narrative therapy is the hypothesis that the act of telling someone about problems is, in and of itself, is a form of change. By discussing the problem, the client is given the opportunity to identify value systems and see themselves in a broader context, which allows them to see the vast possibilities in front of them. This can help

patients identify themes that exist between their previous life choices and the development of problematic belief systems. Experiences and values can now help guide a patient in a new direction and they may feel less "stuck". This process gives patients a sense of control, which as discussed previously is important to those with AN. They will create "alternative" or "preferred" storylines that are in stark contrast to the problem narrative. By doing this they will provide contrast to the problem, reflect their true nature, and be able to rewrite their story. This is done using narrative techniques that include deconstruction/reconstructing and celebrating/connecting.

Deconstruction is another technique utilized heavily in narrative therapy. This technique is the process of breaking down assumptions and replacing them with clear understandings of how beliefs have been established and maintained throughout the life span. This process enhances awareness of the dominant storyline and allows both the therapist and client to explore different paths (Walsh, 2010). The process of exploring and creating a new narrative is called reconstruction and it is in this space goals can be set that are more aligned with the patients true identify (Walsh, 2010). This process will target the core psychopathology of AN; perfectionism, drive for thinness, and body dissatisfaction. Particular focus on body dissatisfaction will be implemented in this treatment modality, as other treatment programs have not seen a successful reduction in this trait. Because this trait is closely linked to identity formation, narrative therapy may offer a more targeted approach and therefore a reduction may be seen.

After reconstruction, narrative therapy focuses on social connections and finding a place in the world that best suites the patients new found identity. Those with AN may have lost important social connections such as friends, family members, and involvement in group activities. Re-establishing these connections is known as personal pilgrimage (Allen, 2012).

This stage of therapy addresses the AN patient's need for external supports, which was stressed in the literature.

Core Assumptions

The core assumption in the creation of this treatment manual is that AN has become a part of the client's narrative and therefore a part of their identity. According to the reviewed authors, it appears that patients with AN often see their disorder as a part of their identity (Gorse et al., 2013; Gulliksen et al., 2012; Paulson-Karlsson, & Nevonen, 2012). Ambivalence to treatment and recovery is often expressed when such loss of identity is seen as at risk by the patient. Therefore, something as basic as weight gain leads the patients to feel a loss of their identity and therefore triggers ambivalence to recovery or results in a sudden refusal of treatment. In a paper by Amianto, Northoff, Daga, Fassino, and Tasca (2016), they define AN as a disorder of the self. They argue that individuals with AN have a difficult time integrating experiences into one core identity. Therefore, this manual's main focus is on altering the client's story (identity).

The Treatment Manual

Utilizing a narrative therapy orientation to create this manual provides a framework to create a specialized treatment. Narrative therapy was chosen because it is flexible in its approach and thereby it can mold to fit each patient uniquely, while still providing clinicians with a standardized manual. It addresses the limitations in other treatment programs mentioned earlier in that it has a heavy focus on identity demonstration and reformation. The following is an outline of an 8-week treatment program, broken up into 3 separate phases. Pre and post measures should be taken at the first and eighth session and will be assessed utilizing the Eating

Disorder Inventory 3 (EDI-3). The EDI-3 is a standardized assessment to measure the symptomology associated with eating disorders. The pre and post measure will allow therapists to evaluate the effectiveness of this treatment manual and to assess if the client needs additional treatment at the end of the 8 weeks. This manual is intended for adult women who meet the DSM-5 criteria from AN. It may benefit those who have gone through more traditional treatment programs and have not been successful.

Phase 1: Deconstructing the AN narrative (3 sessions)

Session 1: Assessment and Externalization

During the first session, the therapist will administer the EDI-3 to measure the client's severity of AN symptoms. The therapist will therefore establish a pretreatment measure. After the assessment is completed the therapist will begin to have what is referred to as an "externalizing conversation". This will be done by have the client first name the disorder. For example, common names are Anna or Ed, but it is to be made clear that the client pick a name that fits their personal experience of their AN. This personalization will allow two things to happen. First it allows distance. By naming their disorder it creates separation from one's sense of identity and the struggles they face as a result of AN. This separation is vital in creating a space whereby the client can take an observer stance, which may help bring perspective and prevent emotional flooding. Second, it allows the client to personalize the therapeutic experience. It is important for therapists who are utilizing a manualized treatment, as is the case here, to remember to tailor the treatment as much as is deemed necessary to maintain rapport and buy in. Once the client has named AN, the client will create nametags, one for their AN and one for themselves. These nametags will be utilized in Phase 2. Encourage the client to be creative

with their nametags and expressing traits that are true to self and traits that are a result of AN. The therapist invites the client to draw two nametags, one for the client and one for AN (name chosen for AN). While creating the nametags, encourage the client to style the nametag based on the who they are creating if for. By asking the client to "step into the mindset" of both self and AN, it sets the stage for future sessions by highlighting and emphasizing the separation between self and AN. The client will then be asked to participate in a visualization exercise. The following script will be read aloud.

I would now invite you to close your eyes. Take a deep breathe in. And out. (repeat until client appears to be in a state of relaxation). I would now like you to imagine that you are in a room sitting in a chair, much as you are now. Across from you is an empty chair. Visualize the room. What can you feel? See? Hear? Now I would like you to imagine that AN (use name chosen for AN) is leaving your body. AN is now a separate entity and no longer resides in your body. An takes a seat in the chair across from you. What do you see? What colors, shape, and size is AN. Take your time imagining what AN looks like and when you are ready, open your eyes.

Once the therapist has completed the visualization exercise, talk about how the process went. Was it challenging? Why? It is important that the therapist allow time and space for this process to occur, as it may be a very different way of thinking about a problem and some clients may be resistant or feel silly or uncomfortable. Once the client is able to "see" AN, they are encouraged to draw it. Once again, the research demonstrating the effectiveness of art therapy on the treatment of AN is limited. According to Frisch, Franko, and Herzog (2006) art therapy helps bring about personal growth and offers a unique treatment avenue for the eating disordered client. Therefore, while there is little empirical data to support the usefulness of art therapy in

the treatment of AN, it is nonetheless a way to elicit depth and self-discovery and will be a vital tool used in this treatment manual.

Session 2: Name tag conversation

In this session, the therapist will use the name tags created in the previous session to trace the history of the problem and explore the effects of the problem. The therapist will ask the client to first put on their own name tag and ask the following questions:

1) When did you first notice the AN? How long ago?
2) What do you remember before the AN entered your life?
3) When was the AN the strongest? When was it weakest?
4) What was it like for you 6 months ago? 1 year ago? 5 years ago? What did you notice about the AN? How much of your life did it have?

Tracing the history of the problem is helpful because it allows space for the consideration of other stories about the problem (Morgan, 2000). When the problem is viewed over time, the client can begin to see it as a changing entity and less fixed. It may offer a sense of relief to realize that the problem has changed over time. It can allow for a feeling of fluidity and replace feelings of being stuck or helpless. It can allow a client to see times where they may have had more influence over the problem, in this case AN.

The client will then be asked to put on the nametag of AN and are asked the following questions:

1) How do you view (client's name) relationships? Do you value her parents/friends/spouse?
2) How do you view (client's name)?

3) How have you affected (client's name) mood and feelings?
4) How do you feel about (client's name) work/school/responsibilities?
5) How do you view the world and what are your beliefs about other people?

By asking these questions from the perspective of the AN, the client is able to explore the effects of the problem. Again, the problem is viewed as external to the person, and the nametag switch calls attention to this framework and conceptualization. This activity will allow both client and therapist to gain an understanding of the ways in which the problem has affected the client's life. The therapist is encouraged to spend time exploring each question thoroughly in order to fully appreciate the distress and/or worry their client is facing.

Session 3: Deconstruction

In this session values will be assessed, and a discussion of the cultural creation of shared values will be highlighted. It is important for both the therapist and client to understand how culture has influenced and assisted in the creation of their problem narrative. The "culture of thin" has plagued young women in western society. Additionally, a woman's worth in society is often based on her physical appearance. The societal belief that "thinness equals beauty" has very damaging results on women and contributes to the problem saturated narrative that clients with AN have created. Breaking down standards of beauty will allow the client to look at their AN in a broader context. Once these cultural constructs are broken down or deconstructed, the client can have a deeper understanding of their negative beliefs and how they were created. Giving a broader context also has the added benefit of shifting blame, while still allowing for ownership of actions. Shifting blame allows space for the client to reduce shame or embarrassment they may be carrying as a result of the AN. Shame can be an overpowering

emotion, which slows the progress of therapy and may cause clients to retreat.

In order to deconstruct societal values, begin by providing psychoeducation. Psychoeducation on the impacts of viewing images of skinny women will provide clients with knowledge of the damaging nature of such exposure. An article by Boothroyd and Tovee (2012) demonstrates how a visual diet can change a woman's preference for the ideal body size. They found that women who viewed many images of skinny women shifted their standards of what body size they felt was aspirational. This study and its results are shared with the client to provide psychoeducation on the process of internalization of society's "value of thin" (article found in this link: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0048691). The clinician will then ask the client to share any personal experiences they have with the value of thin. While the client may have internalized this value, it is important that the therapist encourage separation of this value and the client. Externalizing conversations will continue to be utilized, in order to create distance between the value of thin and the client. The client is asked to think of other values that are assumed if this standard is believed. If the client has difficulty with this the therapist may provide the following examples; beauty equals being thin, women are valued only by their appearance.

Next, have the client use their name tag and list values and beliefs that are important to them. Once a list of values has been made, ask the client to contrast this with a list of values that the value of thin subscribes to. In this comparison, the client will observe the difference between their own values and the values the problem narrative subscribes to.

Phase 2: Finding and mapping unique outcomes (3 sessions)

Session 4: Unique outcomes

In this phase of treatment, the focus shifts from conversations about the problem narrative to creation of a new one. In this session, the focus is on discovering situations and experiences that differ from the problem narrative. This is detective work, where the client and therapist are uncovering pieces of the puzzle that don't quite fit the mold. The client is asked to write down events in which they did something different than what the AN wanted them to do. Have them use their nametags and discuss what they did (i.e. went out for lunch with a friend) and what the AN wanted them to do. In order to highlight the amount of control they had in those moments the therapist will utilize the metaphor of a car. This metaphor will be enhanced by utilizing 2 chairs, set up side by side indicating a driver's seat and a passenger's seat. When the client has their nametag on and are describing a unique outcome they will sit in the driver's seat of the car (on the right side). When they are wearing the AN's nametag they will sit in the passenger's seat. This activity can be repeated as many times as the therapist and client feel necessary to build confidence in the client. This feeling of self-efficacy is very important to instill, as the feeling of having no control may be acting as a self-fulfilling prophecy and contributing to relapses. The goal is to have the client understand, acknowledge and believe in their own power.

If the client has difficulty thinking of unique outcomes, the therapist will continue to be curious and ask questions aimed at identifying an outlier event. It is important to recognize that even a very small deviation from their norm can be classified as a unique outcome. It may also be helpful for the therapist to have been listening for unique outcomes during the previous sessions and remind the clients of these stories. It is best that the therapist uses as closely as possible the same language as the client used, as the therapist does not want to label the unique outcomes if the client does not see it as such.

Session 5: Map history and meaning of the unique outcomes.

In this session, the focus is on connecting the unique outcomes to create a cohesive alternative storyline. The therapist will have the client utilize a visual timeline (shown in appendix) and write down in consecutive order when unique events happened in the context of their life. The client is asked to add significant dates that they feel have contributed to their identity and add the unique outcomes as they fit into their major life events. Meaning making is important at this stage of the therapeutic process. Meaning can be enhanced or constructed by asking the client questions such as:

1) What do these unique outcomes say about you?
2) How have you managed to stop the AN from getting worse?
3) Can you tell me a time when you resisted what the AN wanted and did what you wanted instead?
4) Are there times that the AN is weaker or times where you were stronger?

By making meaning of their unique outcomes, clients begin to uncover a new and separate storyline from their problem narrative. This alternative perspective is called the alternative story in narrative therapy.

Session 6: Name an alternative story.

In this session, the client is asked to name their alternative story that was created in session 5. Once named, the client will be asked to create endings to a choose your own adventure book (see appendix). The endings will reflect the perspectives of both the problem narrative and the newly constructed narrative. Clients will be asked to write what each storyline's likely ending would be five years from now. For clients who would prefer to draw, a

cartoon/comic strip version can be substituted.

Phase 3: Thickening the alternative story (2 sessions)

Session 7: Re-membering conversation

In this session, the client and therapist look at "characters" in the two stories created (problematic narrative and alternative narrative). These people, or members, may be contributing to the problematic narrative (i.e. a friend who values thinness and is constantly dieting or talking about her weight). The client is asked to write down on cue cards the members of their life. They are then asked to place each card on the nametag (storyline) that they belong to. The client is encouraged to think of members that will enhance and embrace their new storyline. The members could be people who are currently supportive in their life and people who they imagine would be (deceased loved ones, mentors etc.). The client is also asked to examine those people in their lives that may be contributing to their problem narrative and with whom they may wish to reevaluate their membership in their life.

Session 8: Outsider witness and ceremony and Assessment

In this session, the client is asked to invite a member of their lives that they feel will be supportive and enhance their newly constructed narrative. The client will then be asked to share the work that has been done over the last 7 sessions, including the name that was given for the AN, their unique outcomes, life timeline and the name for their new narrative. It is encouraged that the client shares their experience in any way they would like. This could include utilizing drama therapy, in which they act out the transformation from their old narrative to their new narrative. When the client has shared their story, the therapist will present a certificate. This act of celebration allows the client to acknowledge their transformation.

The EDI-3 will be administered and will serve as a post measure. This will allow the treating therapist to see if this treatment manual resulted in reduction of AN symptomology. Understanding the effectiveness of this treatment manual is important for both the individual client and for enhancement of evidence-based treatment options for the treatment of AN. It is therefore encouraged that treating psychologists continue to pursue research in this area and publish any results that would assist in providing evidence of the effectiveness of this manual.

Strengths and Limitations

One strength of this manual is that it has been designed to highlight identity deconstruction and formation as the main therapeutic focus. Discussion on weight and BMI have purposely been excluded from the sessions, due to potential resistance. This may help to reduce dropout rates. Additionally, narrative therapy utilizes client driven metaphors by using the method of externalization. By allowing the client to drive the process of therapy, this manual provides flexibility and an individualized approach within the structure of a standardized method. This provides "the best of both worlds", with both a standardized manual and an individualized custom approach.

One limitation of this manual is that the mechanisms of change in treating eating disorders are not known. There is limited research in this area and even less knowledge about how treatments that show promising findings work. Therefore, if treatment is going well, following this manual will be straightforward. However, if the treatment is not working, it will less clear on the direction to go and will vary on a case to case basis. Therefore, it will be the individual psychologist's discretion to broaden the theoretical frame and utilize concepts from other orientations such as CBT to provide alternative strategies.

Ethical Considerations

Due to the serious health implications of AN, which can result in fatality, it is important for clinicians to intervene when needed, as the protection of life overrides the clients right to autonomy and decision making. While it is important to maintain rapport and a good client-therapist relationship, the health and safety of the client must take precedence. Involuntary hospitalization may damage rapport if steps are not taken to ensure the relationship remain intact. Therapists should have very open and honest conversations about the possibility of hospitalization with their clients, however, must do so in a way that does not deter their client from attending treatment.

Summary

The core assumption in the creation of this treatment manual is that AN has become a part of the client's narrative and therefore a part of their identity. Utilizing a narrative therapy orientation to create this manual provides a framework to create a specialized treatment. Narrative therapy was chosen because it is flexible in its approach and thereby it can mold to fit each patient uniquely, while still providing clinicians with a standardized manual. It addresses the limitations in other treatment programs mentioned earlier in that it has a heavy focus on identity demonstration and reformation. This manual allows for ease of implementation, as the program does not require a great deal of materials. Its focus is on enhancing the relationship between client and therapist and allowing the client to shape their own recreation of their identity. The ease with which this manual can be administered will increase the likelihood of therapists delivering and learning a new treatment modality.

CHAPTER IV. DISCUSSION

Anorexia nervosa (AN) is characterized by refusal to maintain normal body weight, an intense fear of becoming obese that does not diminish despite weight loss, and a distorted body image resulting in a feeling of being overweight. Current understandings of the etiology of anorexia are still widely unknown and there is little empirical evidence to determine best treatment practices. The various findings in the literature regarding the best way to treat AN, the multidisciplinary teams involved and treatment atmosphere utilized to treat this population, suggest that inconsistencies in treatment is likely to continue. It therefore seems essential that research continues in the treatment of AN and empirically validated manuals become available for those working with this population.

Existing Treatment

Cognitive-behavioral therapy (CBT) is considered the treatment of choice for AN and can be used in both inpatient and outpatient settings (Halmi, 2005). While there have been studies to suggest that CBT is an effective treatment for AN, it is important to note that other studies that have compared CBT to other treatment modalities were unable to determine clinical superiority of any one treatment (Grange, 2016; Zipfel et al, 2009). Zipfel et al.'s (2009) study randomized 242 patients with AN into three treatment modalities; CBT, focal psychodynamic therapy, and treatment as usual and found no statistical difference in outcomes. Studies like this suggest that treatment of AN should not be viewed as a one size fits all and therefore there is a need to create individualized treatment modalities for those patients that may not respond to CBT or other well test psychotherapies.

A number of authors have shown the benefit of a variety of approaches to treatment as a response to patient needs and have designed programs to accomplish this. For example, Cognitive Remediation Therapy (CRT), as used by several of the studies reviewed, increased patient flexibility of thinking and increased their use of gistful information-processing as opposed to detail-orientated processing. Because it does not focus on weight gain in its initial stages, CRT is ideal for patients who have low motivation and who have higher body mass at the start of treatment (Lock et al., 2013). Such treatment strategies as CRT contrast with other treatment modalities, which focuses on re-feeding and weight gain early in the treatment process, and therefore treats the negative impacts of starvation on cognitive brain function (Couturier et al., 2013). Group therapy, on the other hand, might be ideal for those who have feelings of isolation in association with their disorder and need healthy social interactions (Goldstein et al. (2011). These examples illustrate the benefits of the creation of new and innovative treatment modalities that enhance a client's chance of finding the right fit for them.

Can Outpatient Programs Address Patient Needs?

In designing this treatment manual, the question of whether outpatient programs are effective needed to be answered. In summary, findings show that outpatient programs can result in increased patient readiness-for-change, better response to patient needs, program ability to address core psychopathology traits of this disorder and provide improved patient external supports to increase effectiveness of treatment (Couturier et al., 2013; Goldstein et al., 2011; Lock et al., 2013; Schnicker et al., 2013; Wade et al., 2011; Whitney et al., 2008). It is also clear from the evidence presented in these studies that the trend toward the use of specialized

outpatient programs, and thereby better responding to patient needs, presents much promise as a useful supplement to inpatient programs.

What Would A Narrative Therapy Treatment Manual Look Like?

The manual proposed here consists of three phases: deconstructing the AN narrative, finding and mapping unique outcome, and thickening the alternative story.

Grounding a treatment in a narrative therapy orientation will provide strengths that other programs do not offer. One such strength is the process of externalization, particularly because those suffering with AN see their disorder as a part of their identity (Gorse et al., 2013). Externalizing the problem as a form of treatment was supported and discussed in the research literature reviewed (Couturier et al., 2013; Gullikesen et al., 2012). Externalization is done by using language that allows for the separation of problem and identity. People often find a great relief in doing this as it opens space for them to work cooperatively to revise their relationship with the problem. Problems also seem less fixed and restricting and their skills become more visible. Externalizing conversations reduce guilt and blame; however, they also leave room for responsibility. Separating the disorder from the person would therefore help the patients see themselves in a new and healthier way.

Clinical Implications

Several treatment considerations found in the literature have informed the creation of this manual. One such article was by Jarman, Smith, and Walsh (1997). They considered the importance of therapists' understandings of anorexia nervosa, particularly the construct of control. This manual takes into consideration the high potential for conflict with clients and its aim is to reduce or eliminate this power struggle. By utilizing a narrative therapy framework, the

therapist sees the client as the expert and themselves as an ally. While the goal of therapy still remains the same as other treatment approaches (to treat symptoms of AN), it does so with a softer touch which will lead to less resistance and ultimately less dropouts.

Another consideration in the creation of this manual, and found in the literature, is that there is a lag between recent research findings and their application. It is therefore important to not only continue the research and creation of effective AN treatment modalities, but also to research which factors are seen as barriers to implementation. This literature review demonstrates the importance of understanding clinician's views and perspectives, and therefore this manual was created with ease of implementation in mind in order to increase the chances of implementation.

Recommendations for Future Research

Pilot studies on this manual should be conducted. It is recommended to investigate the efficacy of instructions, how overall administration plays out, and conduct statistical analyses of the EDI-3 assessment scores. Demographic information including experience with other treatment programs, e.g., CBT etc., should be recorded as well to verify the manual is effective with patients who have not responded to "traditional" treatment programs.

Conclusion

The life-threatening nature of Anorexia Nervosa makes the creation of new and innovative treatments all the more important. Those suffering from AN, their loved ones, and those who are treating this disorder deserve the attention of researchers to help provide answers of how to treat this disorder. My hope in the creation of this manual is to offer a program that heals those with AN and to inspire the psychological community to continue innovating,

studying and applying treatments in order to serve each individual to the best of our abilities.

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Appendix A

7. Outcome of Determination (to be completed by the IRB Chair only)

*If 5A and 5B are checked and at least one of 5 C-F is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If J (b) is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If G, H or I, K (including all subcomponents of I) or J (a) are checked then your activity is in a category that the IRB has determined **DOES NOT** represent human subject research and no further submission of Form II or III is required. However, it is recommended you document this determination by placing a copy of this completed application in your files to address any future queries about the project. This form may still be submitted for an official determination by the IRB if required by the sponsor.*

IRB Chair Certification:

Based on the information provided this proposal:

DOES ☐ *constitute Human Subjects Research and the Investigator should submit Form II or III for further review of the protocol. Research cannot start until Form II or III is approved by the IRB.*

DOES NOT ☑ *constitute Human Subjects Research and the IRB will not review it further. However, if changes to the proposed research plan occur that makes the protocol IRB-reviewable, the Investigator is required to complete a new Form I and Forms II or III as required.*

Signed,

04/17/2020

IRB Chairperson *Date*

Appendix B

Choose Your Own Adventure Planner

<table>
<tr><th colspan="8">Start the Story</th></tr>
<tr><td colspan="8">Where would you like to go?
Option 1:
Option 2:</td></tr>
<tr><th colspan="4">Option 1</th><th colspan="4">Option 2</th></tr>
<tr><td colspan="4">Where would you like to go?
Option 1a:
Option 1b:</td><td colspan="4">Where would you like to go?
Option 2a:
Option 2b:</td></tr>
<tr><th colspan="2">Option 1a</th><th colspan="2">Option 1b</th><th colspan="2">Option 2a</th><th colspan="2">Option 2b</th></tr>
<tr><td colspan="2">Where would you like to go?
Option 1a-1:
Option 1a-2:</td><td colspan="2">Where would you like to go?
Option 1b-1:
Option 1b-2:</td><td colspan="2">Where would you like to go?
Option 2a-1:
Option 2a-2:</td><td colspan="2">Where would you like to go?
Option 2b-1:
Option 2b-2:</td></tr>
<tr><th>Option 1a-1</th><th>Option 1a-2</th><th>Option 1b-1</th><th>Option 1b-2</th><th>Option 2a-1</th><th>Options 2a-2</th><th>Options 2b-1</th><th>Option 2b-2</th></tr>
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