Revista
Portuguesa
de
Psicossomática

Application of narrative therapy to anorexia nervosa: a study case

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Abstract

In this article the psychological intervention undertaken with a teenage girl with Anorexia Nervosa diagnosis is described. The intervention was based on the Re-authoring Model by White and Epson and focused the analysis of the "fear of becoming fat" as being the most disturbing one identified by the teenager. Three essential dimensions were emphasized in the therapeutic process of the anorexica: (a) the externalizing language; (b) the discursive context of the problem; and (c) the identification and amplification of moments of active resistance to anorexia nervosa. The continuous and contextual assessment suggests the importance of the construction and projection of alternative narratives, that is, more flexible narratives adapted to new contexts for the resolution of the body related fears and, consequently, for the anorexic's better functional life.

Key-words*: Anorexia nervosa; Narrative therapy.*

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INTRODUCTION

The Re-authoring Model by White and Epson

Our intervention in the field of anorexia nervosa is based on the re-authoring model by White & Epson [cf. 1-3]. The sessions of our intervention were planned and adapted to anorexia nervosa according to the guidance developed from this model and proposed by Gonçalves and Henriques [2].

In White & Epson's model, therapy is characterized as a creative process co-built by the client and the therapist. As mentioned by Gonçalves and Henriques [2, p.27], *"the collaborative relationship is an aim in itself, and not a simple means so that the client can admit what the therapist wants. The therapist raises questions to know and not because he already knows"*.

The generic aim of the psychotherapy is the construction of alternative narratives, more flexible and adapted to reality.

In this model there are three essential dimensions in the therapeutic process: (I) externalizing language; (II) discursive context of the problem; (III) identification and amplification of unique outcomes.

The *externalization* consists in making the problem become a separate entity, external to the individual. It is an attitude which should be taken by the client and stimulated by the therapist.

Throughout this process two aspects are concretely analysed: (a) the influence of the problem on the individual, and (b) the individual without the influence of the problem. The latter is explored through the projection of alternative metaphors to the problem (which the problem does not dominate), and through the strengthening of the sense of authorship, that is, the stimulation of the individual's leading role in this process of solving the problem [2].

The use of metaphors in psychotherapy has shown good results. Metaphors can simplify the introspection providing new solutions and increasing communication between the client and the therapist. They ease the expression and the structuring of thoughts and actions and can also motivate a certain move away of people in relation to threatening affective experiences.

As to the application of the externalizing language in the anorexia nervosa intervention, we can summarize that the aim of this work with the anorexic girl is to help her understand what type of strategies the "anorexia nervosa" (as a separate entity) uses to influence her and what strategies she herself could implement to reduce its impact.

The *discursive context of the problem*, another dimension of the therapeutic intervention proposed by White and Epson, points to the analysis of the ideas and beliefs resulting from social, cultural and discursive factors which strengthen the continuity of the problem [2]. During the question process the person's attention should be called to the established interactions and to the impact resulting from the political, social and cultural environment where the narrative was built. In ano-rexia nervosa the study of this dimension is of utmost importance as the ideals of beauty and of a thin body are extremely stressed in our society.

As the discursive context and the externalisation of the problem are developed, it is common for *"exceptional moments not dominated by the problem"* to emerge[2, p.20]. Those moments are called "*unique outcomes*" and are events contradicting the speech saturated by the problem. The tendency is to ignore or undervalue those moments when the narratives show a higher grade of lack of functionality.

The minimum changes should be explored as examples of the strength over the dominant story or as indicators of the emergence of a new story. Even the microscopic changes at the level of thought or behaviour should be seen by the narrative therapist as important starting points for the construction of new narratives [4]. Thus, the therapist's function is to bring to the conscious level of the patient these unique outcomes. To achieve that purpose he should consider with the client certain inconsistencies in his/ /her narrative (they could be either at the level of situations, thoughts or

emotions), or attempt that the individual might analyse the problem in different ways (for example, by imaging him/herself in another time or in another context), or suggest that the individual anticipates unique outcomes in a near future or even analyses imagined unique outcomes [5]. However, the identification of the unique outcomes should not be understood by the individual as a devaluation or negation of the problem, nor should it be made before its impact is carefully checked.

The change in the individual is strongly associated to the expansion and consolidation of the unique outcomes [2]. The new narratives that are built, contributing to a re-story of the subject's identity, require to be socially validated so that they can also be consolidated. The social validation involves the presence of other significant persons for the subject. Monk [4,p.20] called this process the *"creation of audience"* and suggested that this audience could be made by the therapist, family members, neighbours, friends or other people important to the subject. Another form of social validation could be to assign the consultant's role to the client by encouraging him to participate in clients' clubs (e.g., anti-anorexia league) or to help other people with the same problem [2]. When playing this role the subject shows his/her skills and goes from a position of a dependent help-needed person to a position of "expert". This principle is emphasized by Guerra [6,7] in other contexts of psychological intervention.

In short, the application of this dimension of the therapeutic process to anorexia nervosa can be summarised in the identification and evaluation of moments of active resistance to anorexia (e.g., to voluntary ingest food without losing control, not to weigh every day, not to do excessive exercise, to avoid the social isolation) and the extension of those moments as a means of acceding to new and more adaptable narratives.

Brief Comments on the Application of the Re-authoring Model to Anorexia Nervosa

Food disturbances have often emerged in clinical contexts mainly in adolescent and young adult girls.

Anorexia Nervosa has as main feature a severe food restriction, with the inherent complications, leading to a significant biological, psychological and sociological morbidity which may sometimes lead to death [8]. According to DSM-IV [9, p.559], the diagnosis of anorexia nervosa is confirmed when the following criteria are present: *"(A) Refusal to maintain body weight at or above a minimally normal weight for age and height; (B) Intense fear of gaining weight or becoming fat, even though underweight; (C) Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight on self-evaluation, or denial of the seriousness of the current low body weight; (D) In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles"*.

Quite often this disease means a psychological difficulty in accepting

the body changes. The body control, through the continuous search for weight loss, becomes the main goal of the anorexic's life; his/her own praise and self-confidence result from a thin body. The weight of this dimension is such that, not so rarely, one can meet patients who prefer to die rather than to gain weight [10]. In the chronic course of this pathology the anorexic finds the anorexia itself responsible for his/her existence [11].

In this sense, one can conclude that this illness is assumed by the subject as a way of life, thus being quite difficult to drive her/himself apart it in order to be able to face up to it (i.e., to realise its consequences and to oppose it). We can say that as anorexia is developing it is strongly deepening in the subject. This feature leads us to consider that the intervention proposed by White and Epston is the right one for this kind of disturbance as the externalization of the problem is a main tool in the therapeutic approach.

On the other hand, and as already referred, the authors stress that the preferential targets of this intervention are the cases whose narratives are problem-saturated and whose implications cover various areas of life. In anorexia nervosa this criterion of showing the connection of other operating areas is certainly present and reinforces the model's applicability relevancy. Our conviction is additionally strengthened by White himself [12], who, based on his own clinical experience, considers this approach as efficient for the treatment of anorexia nervosa.

Another feature that influenced our option for this model was the pressure that social and cultural factors exert on the development of this illness. Nowadays, the ideal of beauty is associated to certain aspects like success, personal skill, success in interpersonal relationships and financial happiness, which raises in people the wish of becoming thin. In this way, and although the multifactorial nature of anorexia nervosa is presently recognised, the social-cultural factors continue to be appointed as influential in illness perpetuation [13,14], emphasizing the importance of carrying out the discursive context of these factors in therapeutic context.

CASE STUDY

Clinical Evaluation

Ana's evaluation was based on the evaluation interview model suggested by Gilbert[15] for patients with eating disorders.

The evaluation focused the following aspects:

1) Nature of the problem;
2) Situational factors associated to anorexia nervosa;
3) History of weight and diet;
4) History of attitudes towards food and eating;
5) Attitudes towards weight and body image;
6) Present symptoms (e.g., depression, anxiety, concentration capacity, feelings);
7) Consequences in subject's life;
8) Family story;

9) History of previous treatments and expectations for the present treatment.

Clinical history

Name: Ana[1]

Age: 18

Diagnosis: Anorexia Nervosa, Restrictive Type.

Ana is being supervised at Santo António Hospital and when she started the treatment her weight was 43kg [(Height=1.66m; Body Mass Index (BMI)=15.6)].

Ana had Anorexia Nervosa since she was 14 years old. By that time she thought she *"was fat"* and started having eating restrictions and doing intense physical exercise. She weighed 55kg.

She kept this eating pattern for about 2 years with progressive weight loss. When she was 16 years old she increased the eating restriction, had just one daily meal and reached 37kg. Then, she searched for psychiatric support at random, but didn't want to be supervised with more continuity. In the following year she gained weight but kept on having restrictive eating.

At 17 years old she started a depressive process with suicide ideation, and due to these symptoms she decided to look for help in the hospital.

Definition of the main aims of the therapeutic process

The intervention aims were determined together with Ana taking into consideration her conceptualization of the problem and the expectations for change. During the clinical evaluation we checked that Ana was extremely afraid of gaining weight but, on the other hand, agreed with the serious need of *"getting rid of anorexia"*. This motivation was shown in the search for treatment and her voluntary presence at the hospital. Thus, we believed that one of the main aims of the intervention would not be the weight gain but the search for a balance at the feeding level and its consequent maintenance. By establishing this aim we considered that Ana could face the treatment (and even our presence) as less threatening, which would increase her motivation for the treatment and would ease the therapeutic relationship.

Another aim which we outlined with Ana was the improvement of her functional level, once her life was shown to be quite disorganised, without any personal investment in any type of activity either at job level (attending classes) or free time.

Finally, we concluded that it would be important to approach the network of meanings related to the illness, this being a fundamental aim in the intervention process. This approach covered the analysis of the malfunction fears contributing to the continuity of anorexia nervosa.

[1] Fictitious name

FIRST APPROACH TO THE PROBLEM

Reflection on the universal nature of the fear

According to Gonçalves and Henriques [2], the reflection on the universality of the fears enables the individual to realise that to be afraid of something is a feature quite common to everybody, whether children or adults, and that these fears can have different proportions, which makes it necessary to dominate them so that they do not to become a problem.

In order to introduce this reflection we placed questions like: *"do you think everybody has fears?"*; *"what will be the function of the fears?"*. We still asked Ana to try to identify fears common to most people and fears about which she was not concerned. Ana considered the "fear of death" and the *"fear of loneliness*" as common to everybody and, specifically, the *"fear of loneliness"* did not worry her.

Identification of problem-fears

This exercise was a first approach to the most problematic fears. The identification of these fears appeals to the consciousness of them and to share with the therapist the difficulties in dealing with them [2].

When facing the need of identifying her biggest fears, Ana mentioned:

(a) fear of becoming fat;
(b) fear of making wrong decisions;
(c) fear that some people don't like me.

The *"fear of becoming fat"* was pointed out without any hesitation and, on the contrary, the other two were referred after a brief reflection.

Building of a "fearmeter"

The "fearmeter" is a tool created by the subject aiming to quantify fear severity. Its use shows some advantages: it provides the therapist with (subjective) indication of fear seriousness, it shows the subject that the fears may have different intensities and are supposed to be dominated [2].

We encouraged Ana to build a "fearmeter" by giving her some examples (e.g., thermometer, tape measure, numeric scale). Ana chose a scale of 0 to 10 and classified the fears as follows:

– fear of becoming fat (10 points);
– fear of making wrong decisions (9 points);
– fear that some people don't like me (5 points).

Ana justified the high rating given to the *"fear of making wrong decisions"* due to the fact that she had to make important short term options, namely in relation to her boy-friend and study continuity.

Fear hierarchical process and choice of the fear to be approached

Ana considered that the *"fear of becoming fat"* was much more significant and disturbing to her than the others and, therefore, she asked to privilege its approach.

EXTERNALIZATION

We started the externalizing ap-

proach by stressing that this would help us know the main strategies used by the "fear of becoming fat".

Exploration of the effects of the *"fear of becoming fat"* in Ana's various life areas

When exploring this context we asked some questions also using an externalizing language (e.g., *"what does the fear of becoming fat compel you to do?"; "what does it tell you about yourself?"*). Ana agreed that the fear[2] compelled her to isolate herself and told her she didn't like her body.

Exploring the aims of the *"fear of becoming fat"*

At this level we asked questions like: *"how does the fear want your life to be?"*, *"what would happen if you let the fear of becoming fat do everything it wants?"*, *"what could you never do if the fear always gave orders to you?*".

Ana answered these questions as follows: "*the fear wants me to eat the least possible and to feel living on the threshold ... it knows I like to feel myself weak ... it also wants me to become pretty. (...) if the fear completely dominated me, I would stay in bed, I wouldn't go out, I wouldn't speak to anybody (...) What could I never do? To be happy*."

Identification of a metaphor of domination over the *"fear of becoming fat"*

The definition of this kind of metaphor shows us the expectations the subject has towards the evolution of the problem. The metaphor should be the most realistic as possible. Tomm [16, p.14] reinforces the importance of this feature stressing that "*es extremamente importante que el terapeuta permanezca muy atento a los efectos problemáticos que puede tener una expectativa demasiado alta para el cambio constructivo. (...) En realidad, com frecuencia es necessario externalizar las 'expectativas irreales' como un componente más del problema (...) a fin de evitar los efectos patologizantes de las experiencias de fracasso, desaliento y desesperanza*[3]". According to this author, the analysis of expectations becomes particularly important when you work with chronic problems as the wish of overcoming them is very intense.

Ana, in turn, showed she had a clear and real vision of the illness by saying*: "I would like to have 60kg and to be happy. I would like not to worry about the weight nor the food. I mean, I would like the fear to go away but as I know that will never happen, I'm going to try only to decrease it"*.

[2] When describing the sessions we will not always state the full expression *"fear of becoming fat"*; to make the language more simple we will sometimes use the word "fear".

[3] "It is quite important that the therapist keeps attentive to the problematic effects that a too high expectation may have for the constructive change. (...) In fact, quite often it is necessary to externalize the 'imaginary expectations' as an additional part of the problem (...) in order to avoid the pathological effects of the experiences of failure, discouragement and despair."

Identity Card of the *"fear of becoming fat"*

We asked Ana to try to make an Identity Card (I.C.) of the fear identifying the largest possible features. The application of this strategy essentially shows two advantages: on the one hand, it confers a specific identity to the fear reinforcing its separation from the subject, on the other hand, it enables us to better understand hand how it works [2].

Ana recorded in the I.C. of the *"fear of becoming fat"* the following: *"Man, bad, controller, big, shadow type, severe. His main pastime is to chase me. What disturbs him is my disobedience. And his main enemy is me"*.

Understanding the body, emotional and cognitive effects generated by the fear

In relation to the *body* effects, Ana just pointed out that the domination of the fear made her feel weak. According to her, she could not identify other body sensations as the fear had no main role in this area.

At the *emotional* level, Ana referred that the *"fear of becoming fat"* made her feel *"highly sad*". At first, this was the only emotional effect she could identify.

Ana's answers meet the various theories that relate the eating disorders with the difficulties in the perception and identification of inner body sensations associated to the emotions [17]. Literature regarding eating disorders has often focused the relationship between the eating pathology and the emotions. Some studies in this field [cf. 18,19] concluded, namely, that alexithymia is related to some psychological traits which commonly appear in this type of patients.

However, we tried to stimulate Ana to identify other emotions by recalling some situations she had referred to in previous appointments as difficult to overcome (e.g., when she felt deeply depressive, when she thought she wanted to die, when she realised she was isolated from all the others, when she felt she wouldn't be able to overcome the anorexia). After reflecting over those moments, Ana added that the *"fear of becoming fat"* made her feel *"anxiety and discouragement"*.

During this intervention we still approached the *cognitive* effects generated by the fear. We asked Ana to analyse the thoughts derived from the fear and what "it" told her that was going to happen. Ana stated that the fear made her think about food and her body *"24 hours a day"*.

Then, we asked Ana to describe some thoughts that the fear arose in her. She proposed to write the thoughts she had had that morning:

"You must eat just a little bit today if you want to go to the swimming--pool tomorrow. Look! You're no longer slim, if you eat more today that's the end! And what about the biscuits? Stop right now! It seems you don't know biscuits are too much fattening. It's 48 calories each biscuit you eat. (...) Have you already looked at your legs? You want to go to the disco on Saturday, don't you? You should have thought about it before. You

know very well those trousers are dirty and if you actually go, you must wear those that make you even fatter".

Ana came to the conclusion that the fear made her think all the time that she needed to lose weight to do specific things she liked (*"if I don't get thinner, I can't go to the beach or go out at night, as I can't put on a bikini nor fitting clothes"*).

IDENTIFICATION OF UNIQUE OUTCOMES

Start of the identification of the unique outcomes achieved so far

We started this process exploring the various moments when Ana faced the fear and she tried herself to confront it.

The main unique outcomes recorded so far are: the accomplishment of the dietician's prescription of eating every 3 hours (unique outcome coming out during the externalizing phase and kept on going along the whole therapeutic process), as well as the ingestion of certain foods considered as "forbidden" (e.g. beans and chick-peas).

To set up a record roll of unique outcomes

We suggest that Ana should set up a record roll where we could write down all the situations showing moments of resistance to the "fear of becoming fat" (e.g., to eat every 3 hours).

Reflection on possible strategies to dominate the *"fear of becoming fat"*

We developed a reflection on the possible strategies Ana could use to dominate this fear starting from the deep study of cognitive and emotional factors which had contributed to the appearance of the already referred unique outcomes.

In follow-up to this reflection, Ana stated the following strategies:

I) "to oppose the fear quite slowly, and to try not to go back";

II) "to mind if the fear isn't going too far in what it tells me";

III) "to answer its persuasion attempts" (e.g., "I'll be happier if I don't think much about food and my weight"; "I was already thin and I didn't feel happier"; "I want to eat and what's the problem?").

We ended the session suggesting that Ana should try to apply these strategies during the following week.

SOCIAL-DISCURSIVE CONTEXT OF THE NARRATIVES

By that time we started the social--discursive context of Ana's narratives and attempted that she identified her resources ("allies") to dominate the fear.

To identify the allies of the "fear of becoming fat" and Ana's allies

The fear's allies are all the discursive, social and family factors that strengthen its continuity. By opposition, Ana's allies, are all the factors

that can counterbalance the fear's allies thus contributing to the control of the problem.

The allies of the "*fear of becoming fat*" identified by Ana were: "*the beach; the discos; to dislike my body; the friends to whom I want to be good-looking; to arrive home and want to be thinner (and thus pretty) to be seen like this by everybody*".

Here again the beach and the discos appeared as two important places to Ana demanding a *"perfect"* body.

The allies identified by Ana as being hers were: *"the strong will; the friends who want me to eat; to be at home and my mother cooks when I don't want to eat; to keep busy in class and not to think about my body and my eating*".

From these answers we could conclude that Ana attributed ambivalent roles to her "friends": either her allies or the fear's allies. When studying this question more deeply, we checked that Ana considered her true friends as her allies and "*people in general*" as the fear's allies.

Exploration of new unique outcomes

At this phase Ana ate a great variety of foods (e.g. spaghetti, butter, fish, chocolate) and she did not feel guilty.

PROJECTION OF UNIQUE OUTCOMES

Establishment of a strategic plan

We encouraged Ana to think about a strategic plan to put her allies into action.

Ana's plan had as main features the structuring of her daily life, establishing timetables and activities such as to attend classes, to study and to be with friends (those who want her to eat). She still considered her determination as a means to maintain the "successes" gained so far.

Using her allies and the strategies to dominate the fear (that she previously identified) Ana agreed to "*accomplish with the eating scheme in terms of food variety and quantity; to learn how to like her body more; to be psychologically stronger*".

New measurement of the *"fear of becoming fat"*

The re-measurement of the "*fear of becoming fat*" allows us to check whether or not there was a decrease of its impact and what is its present influence.

As to Ana, she recorded a decrease of its influence, being the "*fear of becoming fat*" recorded with 7 points (scale 0-10).

Reading and reflection of a letter documenting Ana's therapeutic process

In general terms, this letter is an imaginary disclosure of anorexia nervosa and enables us to point out the externalization of the problem and how the unique outcomes have emerged [(2)]. In this letter we describe how the problem was influencing Ana and we outline the capacities and endeavours made by Ana to fight against the *"fear of becoming fat*". We considered that this letter could con-

tribute to the projection of unique outcomes as long as it summarized the abilities obtained from the start of the therapeutic process.

Just as an example, we show some extracts of this letter which was adapted for Ana from the book by Gonçalves and Henriques [2]:

"I am the anorexia. I command Ana's life since she was 14 and in a quite intelligent way: I convinced her she would be perfect if her body shape was thin." (…) "I knew very well how to take advantage of Ana's qualities: I used her persistence, her perfectionism and her independence. (…) In this way I could isolate her from the others. (...) It's true that I couldn't help having my own problems ... sometimes it seemed she wanted to change and come back to previous life. I failed when I underestimated her determination … I knew she was determined but not to such an extent. Ana realised she can only solve her sadness if she gets rid of me (…). Today I still have some command over Ana's life – though less than what I would like. However, I can still convince Ana from time to time that I can come back … and still make her feel concerned about eating, although it seems to me that she is starting to overcome this phase, because she has been increasingly challenging my orders and rules (she eats every 3h, she eats foods previously not eaten and she doesn't feel so guilty). It seems the old Ana is beginning to want to return to what she was … Well, I wasn't as lucky as I'm used to...".

Exploration of new unique outcomes

Ana kept on increasing the number of *"forbidden foods"* (e.g., meat, rice, croissant); she started feeling physically stronger and tried to get used to weighing 44kg (which means a resistance to the arguments of the "*fear of becoming fat*"). In her daily life she started trying to establish timetables and attended some classes.

She referred to the fact that she was not thinking so much about food and was managing to resist losing 1kg. On this specific point Ana had a very significant verbalization from the narrative point of view: *"I believe eating doesn't mean I'm psychologically weaker but actually I'm trying to change my way of thinking and seeing the anorexia*".

PROJECTION OF ALTERNATIVE NARRATIVES

To socially consolidate the skills to deal with the *"fear of becoming fat"*

The position of significant others in relation to current progres-ses is another way to validate the alternative narratives [2]. When applying this strategy to Ana's case, we tried to understand which was the opinion of the people important to her regarding the abilities she had just obtained.

This approach was not too much deeply studied in view of Ana's small support basis. We could not explore the family's opinion about her progress as, on the one hand, Ana' mother (her closest relative) did not usually ask her any questions about

the anorexia nor how her sessions at the hospital were going on; on the other hand, they were not together for some months since Ana went home just during the school holidays.

Friends' feedback was the area we could better analyse. According to Ana, they were noticing some differences and occasionally expressing her some praise but did not talk too much about this matter in order not press her. Her boyfriend had the same attitude.

To anticipate a future without malfunctioning fears

This approach makes it possible to emphasize the new story [2], and a key--question usually placed is: "*How do you think you will be when the fear is reduced*?"

At this level Ana showed a coherent attitude in the way how she was dealing with this process: "When the fear of becoming fat is smaller I'm going to be psychologically stronger, I'm going to like my body and be happy. I feel, however, it's still too far away. This is a long way… so long that sometimes I think I won't get there. I tell myself not to dishearten: this Summer you're not feeling well and it'll be a terrible Summer, but if you go on endeavouring not to lose weight, next year you'll feel quite better".

ASSESSMENT OF THE THERAPEUTIC PROCESS

Until this session we worked with Ana the externalization of the problem, the analysis of the discursive issues strengthening it and we pointed out all the moments of fight against the problem. After this path we considered to be important to assess the process as a whole by pointing out the most significant moments, the most difficult aims to attain and the main results.

We have, thus, questioned Ana about the changes she had been feeling along the therapeutic process. She pointed out that the biggest difference was the way she was facing the anorexia nervosa by that time: she believed she could overcome the problem and that demanded a daily fight from her. She also referred she felt a higher balance inside her which enabled her to study and to have a more structured life.

The biggest difficulties in all this process were identified as being the acceptance of her body and of her weight.

TO PLAN STRATEGIES TO MAINTAIN AND GENERALIZE THE RESULTS

We asked Ana to record on a paper the strategies she had used to fight the "*fear of becoming fat*". The reading of this list could be an incentive to continue and would also remind her the need of using these strategies. In this list not only the strategies but also her allies were pointed out.

During this session we handed Ana the "list of successes" we were building along the sessions and in which the unique outcomes were recorded. We suggested she could add to it the future "successes".

In this session we still built another list: "list of risky situations". Ana outlined in it the allies of the *"fear of becoming fat"* and what this made her think. To the allies of the fear she added the unstructured life style (without plans), the excessive valuation towards the body and the isolation in relation to family and friends.

ASSESSMENT OF THE INTERVENTION

The assessment of the intervention was not made according to the "weight gain" criterion as, even though the anorexic gained 1kg, we had not expected that during this first phase, she would have weight gain but rather balance her eating and keep on that balance.

As referred by Tomm [16, p.14], "Lo mas importante es la dirección en que evolucione el pacient como persona, esto es, la dirección hacia una vida más saludable y no las dimensiones o la frequencia de los pasos que dé."[4]

Thus, as indicators of the anorexic's evolution we rather used the "unique outcomes" which were gradually achieved, such as:

– food ingestion every 3 hours;
– ingestion of foods usually forbidden;
– lack of blaming in face of a more diverse and frequent eating scheme;
– use of strategies of fight against the "fear of becoming fat";
– decrease of physical weakness;
– slight improvement as to body dissatisfaction.

The assessment was continuous and more systematically made in this latter part.

Although we recorded many evolutions at the level of anorexia nervosa, we cannot consider that the main aim of this intervention – the adaptation to the one's body and a serious decrease of the *"fear of becoming fat"* – has been achieved at the end of these sessions.

The conclusions taken from this assessment points to the relevance of the building and projection of the alternative narratives in anorexia nervosa. We consider that clearer narratives, more adapted to context and more flexible in relation to body and eating, could contribute to the anorexic's better functional life.

CONCLUSION

In anorexia nervosa the psychological supervision is quite often long, with successes and regressions, and it involves the approach of multiple dimensions.

In this case study, along ten sessions we focused the body and eating dimensions, exploring the *"fear of becoming fat"* as the most disturbing one to the anorexic. Although

[4] "The most important is the direction to which the patient evolves as a person, that is, the direction towards a healthier life, and not the size or the frequency of the steps."

the supervision of this patient has not ended with this approach, we chose to outline just this part of the intervention, which we consider to be the basis of all the work made on the body dimension. Other dimensions were still deeply studied later on, but always taking care not to disconnect from the basic notions of the re-authoring model, such as the externalizing language of the problems and the identification and enlargement of the unique outcomes concerning problematic situations.

We think that the therapeutic manual written by Gonçalves and Henriques [2], which was our guideline, even though it is a remarkable proposal of a short therapy, can be applied to problematic situations involving a long supervision (like the anorexia nervosa), the "therapeutic tools" also being important in this kind of intervention.

An important aspect to be outlined concerning the manualized intervention (i.e., on the basis of manuals) we carried out, was that we attempted not to see the steps stated in the manual as a set of prescriptions to follow and we adapted the intervention to the anorexic's idiosyncrasy whenever we considered it necessary. For example, we did not use a lot of amusement materials when exploring the themes and recording the sessions, taking into consideration Ana's age. However, we agree it would have been useful to use some additional means, suggested in the manual, to make the knowledge and identification of emotions easier when Ana showed some difficulties at this level (ex. emotions represented by photos or drawings).

In the structure outlining the intervention we tried to summarize the approached topics by recording for each one the most important reflections coming out along the process. We chose this outlining structure aiming to make clearer to the reader the application of this model. Nevertheless, we are aware of the risk of passing on an idea of a somewhat static intervention, with few interconnections between the different contents, when actually all this intervention was a dynamic, sequential and rich process.

Another aspect of the intervention we would like to emphasize concerns the *"fear of becoming fat"*. Along our clinical experience we have been checking that this fear is often chosen by these patients to be worked in the appointments. This shows us how important it is to realise what the *"fear of becoming fat"* actually means, that is, what implications it involves for anorexics living in such a threatening and weakening way. We think the expression *"fear of becoming fat"* may be reductionist; as other fears can be hidden behind it.

The application of White and Epston's narrative model to this clinical case allows us to outline some underlying features which seem to be quite suitable to the psychological intervention in anorexia nervosa. First, emphasis is given on the qualities and is systematically strengthened at the expense of the analyses of

the deficits associated to the problem. One knows that this population shows not so rarely a low self-esteem and a strong sense of inefficiency; so, these two dimensions could be targets with this type of intervention. And we can still consider that if these changes occur, a change at the signification level in the anorexic may happen and, consequently, new narratives concerning anorexia nervosa.

Another positively surprising aspect was the pace this model demands for the intervention, the sessions changing into true challenges for the subject and for the therapist regarding the discovery of new aspects associated to the problem and of small-big steps towards change. The continuous process giving colour and sense to these steps seems to us quite important for the anorexic who attends the therapy sessions feeling that it is extremely difficult to overcome this situation.

The externalization, probably the basis of all these contributes, is also something new to the individuals with psychotherapeutic supervision. The expectations of self-blaming and problem hiding will be disappearing as long as the subject starts using and seeing herself in the externalizing language. What seems unusual and non-sense at first could be a good tool to understand the problematic situation. In anorexia nervosa this approach has the advantage of leading the subject off the problem (which practically fills in the whole thought), as well as giving her the role of active agent in its resolution.

In our opinion, this approach also allows the motivation for change to be worked, which is certainly an essential factor in the treatment of this kind of pathology. The anorexics mostly want to overcome the suffering they are feeling, but they are not willing to accept that eating is something essential for their well-being. Motivation for change is crucial so that the anorexic can decide to try new situations.

As referred by Gonçalves [2, p.37], *"The narratives do not state realities but rather the realities create them"*. This potentiality of building new significations about problems gives the narrative therapies a reference position in the intervention of anorexia nervosa.

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