

Spring 5-3-2015

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Peers Helping Peers: A Model for Planning a
Support Group for Women Struggling with Eating Disorders

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Honors Project

Submitted to the University Honors Program
at Bowling Green State University in partial
fulfillment of the requirements for graduation with

University Honors

May 3rd, 2015

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Introduction

Americans live in a society where they are told how to look, how to act, and how to live; some of this policing of beauty, per se, is done through the abundance of advertising imagery Americans see on a daily basis. The media—including movies, television, and magazines—portrays a specific image of women. Engeln-Maddox (2006) found that “there is much evidence that one characteristic of this beauty ideal, as represented by the media, is extreme thinness, which in many cases is well below the medically recommended weight for women.” In a recent *USA Today* article, psychologist Sharon Lamb says that “girls today, even very young ones, are being bombarded with the message that they need to be super-skinny to be sexy.” Dr. Nada Stotland, another psychologist, explains that seeing extremely thin models on television and in magazines plays a role in anorexia because young women who are already too thin think their body size is now normal (Hellmich, 2006). Scholars working for The National Eating Disorder Information Centre describe media role as “normalizing what is actually abnormal [and] lending truth to myths and falsehoods” about women’s appearances (Jasper, 1994).

Being bombarded by a certain type of beauty standard has a negative effect on young women; some of the most prominent effects include low self-esteem, body dissatisfaction, social anxiety, and disordered eating behaviors. Repeated exposure to media, as well as its direct and indirect pressures to be thin “constitute risk factors for body dissatisfaction [and] concerns over weight and disordered eating behaviors in adolescent girls and young women,” (Lopez-Guimera, Levine, Sanchez- Carracedo, & Fauquet, 2010). Kazmierczak, Patryn, and Niedzielski (2013) found that one’s image of their own body is determined by information received from peers and through comparison with models promoted by the media, and respondents aimed to achieve “ideal beauty” regardless of health consequences. Other researchers have conducted studies that

identify several predictors of negative body image and disordered eating as they relate to mass media; they include: awareness of the importance of the thin ideal in society, internalization of that ideal, and perceived pressure from the media to be thin (Levine & Murnen, 2009).

Champion and Furnham (1999) found that media “exacerbates the phenomenon of body dissatisfaction” by “consistently portraying thin, stereotypically attractive bodies,” and is “partly responsible for the increase in the prevalence of eating disorders.”

Disordered eating behaviors are, arguably, the most serious consequences resulting from the beauty ideals presented in the media. “Nowadays getting slim is almost an obsession for the majority of young girls and women,” and young people are doing “everything to achieve their own ideal shape including extensive trainings or draconian diets,” (Kazmierczak, Patryn, & Niedzielski, 2013). Those who suffer from an eating disorder, and those who struggle with disordered eating behavior, often face a multitude of other problems as well. Obeid, Buchholz, Boerner, Henderson, and Norris (2013), found that social anxiety and low self-esteem are both risk factors for developing an eating disorder as well as effects of suffering from one. Their results show that a “negative association [exists] between social anxiety and perceived social acceptance” and provide data that indicates “a strong negative correlation...between social anxiety and perceived global self-worth,” (Obeid, Buchholz, Boerner, Henderson, & Norris, 2013).

When an individual is diagnosed with an eating disorder, doctors are most likely to refer that patient for individual cognitive-behavioral therapy (CBT)—in addition to medication and monitoring—as the first option for intervention (National Institute of Mental Health, n.d.). Waite, McManus, and Shafran (2012), found that brief CBT intervention can be effective in treating low self-esteem and other symptoms associated with eating disorders. It has also been

found that incorporating psychoeducation, self-monitoring, systematic desensitization, and cognitive restructuring—elements of cognitive-behavioral therapy—into intervention is effective in reducing body image disturbances in eating disorder populations; participants also report lower levels of depression and eating disorder pathology post treatment (Bhatnagar, Wisniewski, Solomon, & Heinberg, 2012). Individuals suffering from significant distress, low self-esteem, and depressive symptoms—all common symptoms associated with eating disorders—can benefit from CBT intervention that focuses on restructuring negative self-thoughts and enhancing positive self-statements (Clore, & Gaynor, 2006).

Cognitive-behavioral interventions are often implemented in individual therapy settings, therefore lacking the social support that is necessary for eating disorder treatments to be most effective. Limbert (2010) found that, in order for intervention to be most effective, there must be a focus on personal perceptions of social support for individuals receiving treatment for an eating disorder. Support from others is why support group interventions may be more effective in treating the symptoms associated with eating disorders. Peer-support groups have been shown to be a very effective method of preventing eating disorders among adolescent populations (Thompson, Russell-Mayhew, & Saraceni, 2012). There are many different models and structures of group-based interventions that have shown to be effective. Azzato (1997) found that “a support group in which healthy relationships are fostered provides the ideal environment for [a] young woman to explore her ideas, to express and develop her attitudes, to explain her behavior, to receive positive feedback, and to improve her self-esteem.” In doing so, this type of group intervention allows young women at risk for, or suffering from, an eating disorder and low self-esteem to create connections with people experiencing similar problems, therefore creating a support network to help overcome life’s difficulties.

Recent research in the field of eating disorder and self-esteem intervention has focused on newer, more innovative models of group treatment. Black (2003) focused on a “model of group work [that] is based on women’s participation and feedback, and incorporates a review of the literature pertaining to radical feminist group work.” This model of intervention—consisting of four stages: group building, disclosure, challenge, and closure—indicated improvements in psychosocial factors associated with eating disorders. These factors included drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interceptive awareness, and body maturity fears. (Black, 2003). As the research shows, therapeutic support groups can be extremely helpful in improving measures of low self-esteem, body dissatisfactions, social anxiety, and other symptoms associated with being at risk for, and developing, an eating disorder. CBT used in traditional therapeutic settings fails to incorporate the integral component of social support into its intervention; therefore, there is a need for support groups that use concepts from intervention methods, such as CBT, that have a large evidence base to support their success in helping to treat EDs.

Theory of Group Work

Numerous theories exist that attempt to explain how groups form, function, and interact in the context of social work. Systems Theory (ST) explains group as a system of interactive elements, all of which are interdependent on one another. While functioning as unified whole, the group attempts to maintain a state of equilibrium. In order for equilibrium to be maintained, the system must accomplish four tasks: integration, adaptation, pattern maintenance, and goal attainment. Part of ST explains that groups go through a natural process of evolution and development, one in which groups inherently move towards termination without proper assistance. Without support and direction, systems naturally disengage from its sub-parts until

there no system left to observe. Another aspect of this theory asserts that groups are constantly interacting with their environment. Within the context of a therapeutic support group, ST supports the idea that members are continually interacting with each other, with the facilitator, and with their external environment—which might include the sponsoring agency, social services, and outside support systems, or lack thereof (Toseland & Rivas, 2012).

Learning Theory (LT) is another popular theory when working in group settings, though this theory focuses more on the behavior of individuals in the group rather than on the group's behavior. LT emphasizes clear, specific goal setting, contracting, step-by-step treatment planning, measurable outcomes, traceable evaluation, and the influence of the environment on the group and its members. A tenant of LT is Social Learning Theory (SLT), in which learning takes place through observation and vicarious reinforcement and punishment. Group members are able to learn positive and appropriate behaviors by observing others being rewarded for those same actions. A support group provides an environment that fosters social and observational learning among members (Toseland & Rivas, 2012).

Purpose

I have chosen to create an eight-week support group, called Peers Helping Peers (PHP), that will be targeted at young women and teenagers suffering from, being treated for, or at risk for an eating disorder (ED). A support group would allow members to lean on each other for support, and as learning theory suggests, members would be able to learn from others' successes and challenges. Some argue that a support group setting could foster unhealthy situations for women struggling with eating disorders, as they could learn more unhealthy ways to lose weight. PHP is not meant for women suffering from an extreme eating disorder; a pre-screening process would be utilized in order to refer extreme cases of EDs to a medical professional for treatment.

The facilitator would also continue to assess members throughout the group process and would make any necessary referrals if a member's disorder worsens during the progression of the group. This ongoing assessment process would insure members are receiving the best possible treatment for their specific situation. PHP is not a medically-driven intervention option and is, therefore, meant to be utilized in conjunction with another treatment option—such as nutritional counseling, medication, or medical monitoring.

Peers Helping Peers will meet for 90 minutes once a week, with homework to be completed between sessions. There are three main goals for this group: (1) learn about eating disorders, their symptoms, and when those are likely to occur, (2) keep a diary of thoughts and emotions, and (3) build a support network. Support is a key component in the path to recovery for those suffering from an eating disorder, and cognitive-behavioral therapy (CBT) is the “leading treatment” for eating disorders (Murphy, Straebl, Cooper & Fairburn, 2010). Therefore, while the main focus of this group will be to build a support network for members, small components from CBT will be utilized to help increase self-esteem, decrease depression, and improve social support; these components include relaxation, self-monitoring, psycho-education, goal setting, and homework.

By maintaining a support group setting, members will have more control over the direction of the group's discussions and the facilitator can take a more supportive role. It is important that the group members are able to guide the group in a direction they feel comfortable with; a comfortable environment would foster a sense of belonging and openness between members. From a logistical standpoint, the agency sponsoring PHP would be able to save on the cost of hiring or training an employee in CBT because this group only incorporates small elements used in tradition CBT intervention. In addition to being cost effective for the

sponsoring agency, a support group would be an inexpensive—potentially free—intervention option for individuals who may not be able to afford other, more expensive, treatment options for EDs.

Group Intervention Stages

Toseland and Rivas (2012), outline a model for planning and executing treatment and tasks groups. The model outlines the tasks that need to be completed at each stage in the group intervention process—the planning stage, the beginning stage, the middle stages, and the ending stage. Each stage is geared to accomplishing a certain task. The planning stage is when all of the work prior to the execution of the group happens; this is when a venue is secured, the purpose is established, and members are recruited. The beginning stage of the group process is meant to establish a purpose between the group members and build rapport between members and the group leader. During the middle stages, the group gets into the nitty-gritty of the intervention and treatment plan. Lastly, the ending stage of the group is used to tie up loose ends and terminate the intervention process with members; this often involves making necessary referrals and following up with members post-intervention.

Planning Stage

Planning and developing a treatment group is typically the most intensive stage in the group development process. This stage encompasses everything from establishing the purpose of the group, to choosing appropriate assessment and evaluation tools, and recruiting potential group members. Careful attention needs to be given to planning a group because this stage is what builds the foundation for the group. By ensuring everything is done well in the planning stages, group sessions can be expected to run smoothly later on—relieving potential stress for both the members and the facilitator.

Before anything can be done, the purpose of the treatment group must be established. Peers Helping Peers is intended to provide a supportive and therapeutic environment for women, ages 14 to 24, struggling with or at risk for an eating disorder, and other related problems. This support group is intended to target three different measures: body image and self-esteem, social support, and depression. These measures were chosen because they are risk factors for the development of an eating disorder. By the end of the eight sessions, members would hope to experience an increase in social support, a decrease in depression, and an increase in self-esteem and positive body image. By targeting risk factors for EDs, I hope that PHP would decrease the likelihood of members developing, or experience the reoccurrence of, an eating disorder. After target measures are identified, assessment tools need to be chosen in order to measure and monitor them over the course of the eight week group. For PHP, I have chosen four different assessment tools, each of which would measure a different trait. All four assessments will be combined into one survey that would be administered to group members prior to the first group meeting, during the final group meeting, and one more time at a six-month follow-up meeting. By collecting data at three separate points in time, the hope would be to identify whether or not the group was successful in increasing social support, decreasing depression, and increasing self-esteem and positive body image.

The Beck Depression Inventory (BDI) is a 21-item, self-report survey that measures characteristic attitudes, symptoms, and severity of depression (Beck et. al., 1961). This assessment tool is commonly used by a wide range of professionals to help monitor clients' depression levels as they move through the treatment process. The BDI will help identify clients that are experiencing severe depression and should be referred to a psychologist, or another mental health professional, before they partake in a support group such as PHP. I chose to

develop a support group in order to expand the pool of potential members; the BDI would keep PHP as inclusive as possible. The survey requires a sixth-grade reading level in order to understand the questions, so members who may not have had access to high quality education would not be excluded (Groth-Marnat, 1990).

In order to assess members' self-esteem and body image, the Multidimensional Body-Self Relations Questionnaire (MBSRQ) will be administered. The MBSRQ is a self-report survey that targets many different subscales including: evaluation and orientation, appearance, fitness, health and wellness, overweight preoccupation, self-classified weight, and the body areas satisfaction scale (Cash, 2012). This assessment tool will help gauge the members' attitudes and feelings in relation to body image and self-esteem. Another useful tool that will measure body image disturbance is the Body Image Avoidance Questionnaire (BIAQ). This questionnaire is a reliable and valid measure that deals with avoidance of situations that provoke concern about physical appearance. More negative responses on the questionnaire are associated with more intense body dissatisfaction, fear of being fat, feelings of low self-worth because of appearance, greater importance placed on body shape and weight, and a desire to lose weight (Rosen et. al., 1991).

The last assessment tool that will be utilized during PHP is the Eating Attitudes Test-26 (EAT-26), which will help track members' healthy and unhealthy eating attitudes over the progression of the group. Since PHP is targeted for women suffering with an eating disorder, it will be helpful to track their eating attitudes in order to determine if they group is effective in helping alleviate the problems associated with EDs. The EAT-26 has shown to be an effective screening tool for "eating disorder risk" ("EAT-26 Self-Test," 2009), which would be helpful in identifying which members might need other treatment in addition to their participation in this

support group. Each assessment tool chosen for PHP is in the form of a self-report survey and, therefore, will be simple to analyze; the facilitator will not need to be trained on how to interpret the tools.

I chose not to utilize an assessment tool to measure social support because it is incredibly hard to quantify. Measuring members' feelings of social support is a subjective matter, if one individual feels their support network has expanded by participating in PHP, then that would be thought of as a success. It would be unfair to put on number on social support; some people perceive support to a large handful of peers, whereas others may deem one person enough support to help them through the ED recovery process.

One component of cognitive-behavioral therapy that will be integrated in Peers Helping Peers is self-monitoring. Members participating in PHP will utilize self-monitoring through the use of a thought record (Appendix A). This thought record will help group members begin to become aware of triggering events and situations, as well as their negative thoughts and feelings associated with those situations. CBT works to change negative thoughts, emotions and behaviors; it would be difficult to attempt to change those without first knowing what they are. A thought record aides in members identifying these negative thoughts and behaviors before attempting to change them through CBT.

After choosing assessment tools, Toseland and Rivas (2012) outline the importance of reviewing the current literature, assessing potential sponsorship, and recruiting members. When implementing any type of intervention, it is imperative that there is an evidence base to support the chosen treatment. Cognitive-behavioral therapy in relation to body image disturbances deals with the "modification of intrusive thoughts of body dissatisfaction and overvalued beliefs about physical appearance, exposure to avoided body image situations, and elimination of body

checking,” (Rosen, Reiter, & Orosan, 1995). Eating disorders provide one of the strongest indications for CBT (Murphy, Straebl, Cooper, & Fairburn, 2010). There is a wide evidence base for the effectiveness of CBT in treating EDs, but little to no evidence about the use of CBT in a support group setting. PHP would be a trial group that would hopefully begin an evidence base for CBT in a less-structured group therapy setting.

Support groups are an inexpensive treatment option that requires little resources to conduct, though it is still important to find a sponsoring agency that will absorb the costs that do remain. In order to run PHP, a location would need to be secured. The sponsoring agency could potentially provide a meeting space in their building, or connections could be made with local churches or schools to find a room for this group to meet. Other costs that might be associated with running PHP would be purchasing the different assessment tools to use, printing materials for each sessions, and employing someone to run the group—this will often be someone already working for the sponsoring agency.

Recruiting potential group members is a delicate process because membership should be open to all who want to participate, but this needs to be balanced with maintaining a conducive environment to therapy. PHP is a support group for women struggling with EDs, so it would be helpful to reach out to local ED treatment programs for client referrals. By asking for referrals—instead of publically advertising PHP—the group composition would be able to be monitored. In a support group it is important that members are screened prior to the start; individuals who show extremely severe cases of EDs would be referred for more intense treatment before participating in a support group. It is also important to pay attention to members who might create an unsafe or uncomfortable environment for other members; this might involve paying attention to characteristics such as narcissism, pessimism, and brashness. These members would not be

beneficial to creating a supportive environments, and therefore should not be referred to participate in PHP. It is essential to pay close attention to these tasks while planning for a treatment group; a well-planned group sets members up for successful intervention.

Beginning Stage

Once a group has been planned and prepped for, it is then time to begin holding sessions. A support group is intended to be a safe space where members can share their experiences, feelings, and concerns about their problems; this type of environment can be hard to create. Before members feel confident sharing their experiences, they must first feel comfortable and safe around the other members in the group. Members need to form relationships with each other and the facilitator needs to build rapport among members as well. Peers Helping Peers is only an eight-week group; therefore, rapport and relationships need to be established as soon as possible. On the other hand, these bonds cannot be forced; they must be natural, genuine relationships or members will not fully trust other members enough to share such personal emotions. This delicate balance between establishing relationship but letting them develop naturally is where flexibility comes in handy. A support group provides a flexible “curriculum”, so to speak, that allows members to linger on some topics if there is more to be discussed. The facilitator needs to pay close attention to these forming relationships, and address problems and concerns as they arise. To help foster a comfortable environment, during the very first PHP meeting, the facilitator should lead member introductions. It is important to let members pick and choose what they want to reveal about themselves; the group leader should also encourage members to talk about information not related to the issues that brought them to PHP in the first place. By not discussing ED problems from the get-go, a more positive environment can be created to build

upon. After members know more about each other, and feel comfortable in the group setting, it becomes easier for them to hold each other accountable.

Another important step in beginning a group is allowing members to define the purpose of the group. Support groups are meant to help members expand their support network and learn ways to cope with their problems; therefore, it is important for them to define what they want the group to accomplish, even if that goal is different from what the facilitator originally intended. The process of establishing a purpose assures that members maintain control of the group; forcing them down a path they do not wish to take would not be conducive to a therapeutic or supportive environment.

Contracting is also an important aspect when completing intervention with clients. The contracting process—which can be produced verbally or written out—is a mutual agreement between the worker and the client that outlines expectations, obligations of the client and the worker, and tasks that are to be completed during the intervention process (Toseland & Rivas, 2012). Treatment contracts eliminate confusion by outlining each party's responsibilities and the parameters of the intervention. During PHP, contracting would be used in a verbal form and would include: the facilitator's role and responsibilities, expectations of the members, duration and context of the group intervention, and any tasks to be completed during the eight-week group. If members do not agree to aspects of the contract, then one of two routes can be taken; (1) the facilitator can collaborate with the members to reach compromise that everyone feels comfortable with, or (2) the facilitator may recommend a member find an alternate treatment option if the area of concern is non-negotiable—such as confidentiality. It is important this contracting process be completed as soon as possible after the group begins; expectations and guidelines need to be set from the beginning to avoid future conflicts.

The last important task in the beginning stages of group treatment is goal-setting. It is important for members to have one goal, or a set of smaller goals, to work towards during the progression of the group. During group treatment, there are three type of goals that are often identified: individual goals, common group goals, and group-centered goals that would target the functioning and maintenance of the group as a whole (Toseland & Rivas, 2012). Individual goals will be set by each individual and unique to their own problems. An example of this type of goal could be to learn one new coping mechanism that would help an individual successfully handle eating a full meal. Common group goals are those that are the same between group members. As mentioned in the planning stage, PHP is targeted to help decrease depression, increase social support, and increase positive self-esteem and body image; it would be ideal that all members want to see these changes in themselves over the course of the group. The last type of goals are those that are group-centered; these goals are geared towards maintaining the group and enhancing the functioning of the group. Foster a specific group value or increasing communication from quieter members could be examples for group-centered goals. It is important that goals are set early in the treatment process, especially since PHP is only eight weeks long, because it is difficult to move through an intervention plan without a goal or end in sight. The beginning stages of group treatment are integral in building relationships between members, establishing a purpose for the group, and identifying goals to be met during treatment.

Middle Stage

The middle stage of group intervention is when the facilitator and members delve in-depth into the heart of treatment. For Peers Helping Peers, this is when the facilitator will guide members through different discussion topics related to cognitive-behavioral therapy. Each week, the group leader will utilize a pre-planned outline about a specified topic to help members

understand EDs, and negative cognitions, emotions, and behaviors related to EDs. These topics will be conveyed using guided discussion questions by the facilitator (Appendix B); this will help keep conversations related to the intervention, but will also allow members to guide the direction of their responses. Members will then have a homework assignment to complete between sessions. Most often this will be continuing to utilize their thought record. Each week should begin by members sharing how the previous week went---aside from the very first sessions. The facilitator should also review members' thought records with them at the end of each weekly session.

Week 1: Group Introductions. The first session of any group intervention should be centered on introducing members to the group, the facilitator, and the other members. During the first meeting of PHP the group leader will be tasked with facilitating introductions between group members, explaining the purpose of the group, outlining the guidelines and rules of the group, and introducing the facilitator's role in this support group. It is important that members be acquainted with other and the support group environment; members will feel more willing to open up about their experiences if they are comfortable with their surroundings and their peers. When letting members introduce themselves, it would be helpful to encourage members to talk about themselves not in relation to their problems; knowing who members are, and not their disorders, is important in making connections and establishing relationships.

After explaining the logistics of the group and the role of the facilitator, the group leader will then lead a discussion for members. Topics covered in this guided discussion should include: what prompted members to attend PHP, what are their expectations about participating PHP, what are they looking to get out of their participation, and what are they most worried about. Members should be allowed to direct the conversation and interact with each other. These

discussion questions are meant to guide the conversation on an as needed basis during the first half of the meeting.

The second half of the first session will be dedicated to explaining and administering the pre-intervention assessment survey. The facilitator will explain what the survey is, its' purpose, and how it will be used over the course of the intervention. Members will then spend time filling out the survey; the facilitator should be sure to answer any questions group members have. The last thing that needs to be done during the first session is introducing the thought record to members. It is important to spend an ample amount of time with this discussion because the thought record will be used as members' weekly homework assignment. The group leader needs to be certain to explain what a thought record is, its' purpose, and how to use it over the course of the eight-week group. Members should be given copies of the thought record, and it might be helpful for the group leader to show members a couple of examples before answering their questions.

When ending the first group sessions, the group leader should thank members for coming and encourage them to work on their thought records over the course of the next week. While the group's homework is to complete a thought record, the group leader will need to collect and analyze the members' assessment surveys. The facilitator should be looking for any indication that group members may need to be referred for further medical attention or individual therapy. This will ensure that members are getting the best intervention possible for their personal needs.

Week 2: Psychoeducation Part I. The second sessions of PHP will be dedicated to psychoeducation about eating disorders. Prior to facilitating a discussion, the group leader should ask members about the previous week and how they did completing their thought records. This will allow members to ask any questions they have and share experiences with each other. After

ensuring members are on the same page about their homework assignment, the facilitator will transition into the focal topic of the week. Psychoeducation is an important component of cognitive-behavioral therapy that has been incorporated into this support group; “an important first step in overcoming a psychological problem is to learn more about it,” (AnxietyBC, 2007). For members, it can be comforting to know that they are not alone and that others have found helpful strategies to overcoming eating disorders. During this session, the group leader will lead a discussion about the following: what eating disorders are, common symptoms associated with eating disorders, risk factors that increase the likelihood of developing an eating disorder, and when symptoms are likely to occur.

Week 3: Psychoeducation Part II. While the second PHP session focused on what eating disorders are, the third week will continue on the topic of psychoeducation, but will mostly focus on how EDs affect one’s life. This week is intended to dive one step deeper than the previous session. It is intended to help members open up about the negative impact EDs—or problems such as negative self-esteem, disordered eating behaviors, and depression—have on daily life and their relationships with themselves and others. The facilitator should encourage all members to share, but also needs to be careful to not pressure members and make them feel uncomfortable.

Another important component that will be discussed in week three is goal setting. The group leader should lead a discussion with members about where they want to see themselves at post-intervention to assist in members with writing goals. Group participants should set both short- and long-term goals that describe certain things they would like to accomplish at the end of the group, six months after the group concludes, and also a year or two post-treatment. The group facilitator will provide a goal worksheet to help members formulate specific, attainable,

and measurable goals for the course of the intervention. The members will be able to work on the sheet at the end of this session, and would complete the rest of the sheet as the homework assignment—in addition to continuing using their thought records.

Week 4: Recognizing Negative Cognitions. Week four of PHP is when the group delves into the hot-button topics of CBT; the next three sessions will be focus on negative cognitions, emotions, and how they all relate and affect one another. This particular session will focus on helping members to recognize negative cognitions, because it is hard to change something without first recognizing it as a problem. Examples of negative cognitions include, “I am not in control of my eating” or “No one will love me unless I am skinny.” These negative cognitions can be detrimental to an individual’s self-esteem. The group leader would help lead a discussion about members’ own thoughts, types of negative cognitions, and the consequences of negative cognitions. It is important to allow members to lead this discussion so that they are able to figure out their cognitions on their own.

Week 5: Recognizing Emotional Triggers. Recognizing emotionally triggering situations is an important step in recovery. During week five of PHP, the group facilitator will discuss what situations are emotionally triggering to participants. Common emotional triggers for this demographic group might include not achieving certain needs, such as: acceptance, control, love, attention, and respect. Participants experience different emotional triggers, and react to them differently. The group leader will help members identify these triggers through discussion questions in order to facilitate a natural realization of emotionally triggering events. Members will learn how to cope with these triggers during week seven of PHP.

Week 6: Relationship between Thoughts, Emotions, and Behaviors. Cognitive behavioral therapy, particularly in group settings, focuses on teaching group members that one’s

thoughts, emotions, and behaviors are all interconnected; the group leader will use the thoughts, emotions, and behaviors triangle to depict this concept. Examples can be made up to further help explain this phenomena if members are confused. The group leader will use discussion questions that allow participants to explore how cognitions, emotions, and behaviors have affected their life. If members do not come to the conclusion on their own, the facilitator should be sure to explain how habitual, negative thought patterns can trap an individual in the perpetual cycle of negative cognitions, emotions, and behaviors.

Week 7: Coping Skills. Week seven of PHP is centered on preparing members for handling their problems outside of the group setting. In order to successfully recovery members need to be able to cope with their problems once the group intervention is terminated. Learning new coping skills will hopefully reduce the chances of an ED, and other related problems, from reoccurring. Some positive coping skills that can be taught, and practiced, during this session include: becoming involved in activities that are of interest to the individual, staying connected in support groups online, imagine one's self in a safe place, making a list of positive affirmations, getting massages, telling someone that you love them, journaling, getting into nature by hiking or taking walks, and making a list of everything one is grateful for (Ekern, 2012).

Week 8: Concluding the Group. The last week of PHP is dedicated to wrapping up the group's work and administering the post-intervention assessment survey. The group facilitator will lead a discussion with participants about: how members feel the group went; what members will take away from the group; how members feel about the group ending, and whether members met the goals they set during the third week of PHP. Debriefing about the members' thought records is also an important objective during the final meeting. Participants spent the past seven

weeks keeping this record, so it is important to discuss how it helped and if members noticed a change over the course of intervention. Hopefully, by this last week of PHP, members notice fewer occurrences of negative and irrational thinking.

The other major task involved in the last group meeting is administering the post-intervention assessment survey. This survey will help the group leader identify whether PHP helped members experience a change in the target measures—an increase in positive body image and self-esteem, a decrease in depression, and an increase in social support. Before dismissing the group for a final time, the group leader should be able to provide any necessary referrals for members who may need further treatment or intervention; this decision can be made based on members' post-intervention assessment survey. Any member who is experiencing higher levels of depression and negative self-esteem would most likely benefit from additional intervention.

Ending Stage

Ending a treatment group is a delicate task. Group leaders must be upfront about the termination of the group and explore members' feelings about this ending. In addition to discussing the group's end, appropriate referrals may be needed for group members. This might involve referring an individual to additional therapy, employment or educational services, and additional areas where that individual can find support—such as a support group or an online discussion board.

Potential Barriers

Confidentiality

The issue of confidentiality can potentially derail a group if not handled and treated properly. Keeping the information shared within group meeting confidential helps foster a safe environment and helps members feel comfortable. The social work profession lists

confidentiality as one of its core values and ethical principles (National Association of Social Workers, 2008), meaning the facilitator is obligated to maintain confidentiality in most situations—except in situations in which social workers are legally required to report. Even though confidentiality can be expected from the worker, it is near impossible to promise that information will be kept private by other group members; the facilitator cannot guarantee members will not share information after leaving a group meeting. It is important for the PHP facilitator to stress the importance and purpose of confidentiality; they should explain that maintaining members' right to privacy is a sign of respect. Members who do not respect others' rights often create an environment in which individuals do not feel comfortable sharing. If the facilitator is made aware that a member is not keeping group information confidential, then it is important to confront that member and try to help them realize confidentiality's importance. In more extreme cases, when a member's breach of confidentiality puts another member's well-being at risk, then it might be better for the group to ask that member to leave.

Attrition

As with any treatment group or research study, there is always a possibility of losing participants over the course of intervention. Participation in PHP is completely voluntary, and members will not get anything out of their participation if they are not actively engaged and willing to contribute to the group process. Group leaders can limit attrition by helping members create a sense of belonging within the PHP group. If members feel connected to the group and their peers, they are much more likely to continue through with the entire group intervention. If attrition does occur, in that members drop out of participating in PHP, the group leader can still use that to their advantage. When administering the post-intervention assessment, it would be beneficial to include members who dropped out of the course of the eight weeks. By assessing

lost participants' measures of self-esteem and body image, depression, and social support, the facilitator will be able compare those results with those of the members who completed all eight weeks of the support group. It would help identify if PHP was helpful in maintaining positive measures.

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Appendix A
Thought Record

CBT Thought Record						
Where were you?	Emotion or feeling	Negative automatic thought	Evidence that supports the thought	Evidence that does not support the thought	Alternative thought	Emotion or feeling
Where were you? What were you doing? Who were you with?	Emotions can be described with one word. E.g.: angry, sad, scared Rate 0-100%	What thoughts were going through your mind? What memories or images were in your mind?	What facts support the truthfulness of this thought or image?	What experiences indicate that this thought is not completely true all of the time? If my best friend had this thought what would I tell them? Are there any small experiences which contradict this thought? Could I be jumping to conclusions?	Write a new thought which takes into account the evidence for and against the original thought	How do you feel about the situation now? Rate 0-100%

Appendix B
Suggested Discussion Questions and Weekly Homework

Session	Topic	Suggested Discussion Questions	Homework
1	Group Introductions	What prompted you to come today? How are you expecting these sessions to go? What are you hoping to get out of these sessions? What are you most looking forward to? What are you most worried about?	Thought Record
2	Psychoeducation Part I	How have you been doing over the past week? How would you describe an eating disorder to someone? What situations do you find most difficult to handle?	Thought Record
3	Psychoeducation Part II	How have you been doing over the past week? When did you realize there was a problem? How has your life been affected by eating disorders? What would you like to see change? Where do you see yourself 8 weeks from now? 6 months? How are you going to achieve the change?	Thought Record, Goal Sheet
4	Recognizing Negative Cognitions	How have you been doing over the past week? What type of thoughts do you often have? Why are those thoughts negative or harmful? What happens when you have a negative thought?	Thought Record
5	Recognizing Emotional Triggers	What are common emotions you experience? Can you identify situations that are emotionally triggering? What happens when you find yourself in these situations?	Thought Record
6	Relationship between Thoughts, Emotions, and Behaviors	What happens after an emotionally triggering event? Do you see a change in your behavior or thought pattern?	Thought Record
7	Coping Skills	In the past, how have you handled difficult situations? What do you think are more effective ways to cope?	Thought Record
8	Concluding Group	How do you feel the eight weeks went? What did you learn over the last eight weeks? How will you take what you learned and use it? Do you think you met your goals? How do you feel about the group ending? What's next for you?	N/A