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Letters to Anorexia. Narrative tools for working with anorectic patients in a Dialogical Self context

Urszula Tokarska, Dorota Ryżanowska

Human Development Support Psychological Unit,
Department of Psychology, Pedagogical University of Krakow

Summary

Aim. Deepening understanding of the experience of patients with *anorexia nervosa* in the light of a narrative-constructivist approach and Dialogic Self Theory. Exploring the phenomenon of internal dialogues, which occur in patients' minds as an interchange between two competing (healthy and disordered) aspects of their Selves. Describing diagnostic and applicative possibilities of narrative stimuli in the form of "Letters to anorexia".

Method. As was assumed the process of developing/regaining a relative detachment from the internal voice of anorexia, which itself is indicative of progressing recovery, can be both diagnosed and fostered with externalization techniques. Developed for the purpose of the research, a categorization tool was designed to examine two aspects: Self-positioning (positioning above and below the voice of personified anorexia) and autobiographical narrative patterns used by researched persons.

Results. Based on statistical analysis, two different groups of patients were identified: (1) with dominant below-positioning, (2) with dominant above-positioning. Using mixed quantitative-qualitative methodology (including semantic analysis), multidimensional correlations were established within the two homogeneous clusters.

Conclusions. Postulated in the Dialogical Self context, supporting internal dialogue in patients with anorexia nervosa seems to co-exist with subsequent stages in the treatment process, which is reflected in the letters to anorexia written during therapy. A reverse correlation can also be surmised, i.e., the positive effect of the intentional therapeutic triggering of internal dialogue and narrative experience structuring using narrative stimuli such as letters. Authors provide some suggestions for further in-depth research on internal dialogues with regard to application, diagnosis, therapy, and prevention.

Key words: *anorexia nervosa,* narrative therapy, personal documents

Introduction

The theoretical framework of the research adheres to the constructivist-narrative perspective on eating disorders [1–5] in combination with Dialogical Self Theory, which explores the discursive nature of the human mind [6–9]. Empirical research and clinical observations suggest that patients with *anorexia nervosa* (which is the subject of the present study) manifest increased rigidity levels in their Self structures. Such a Self is partially unable to adopt different types of positioning and/or engage in an effective dialogue between them [10–13]. According to Mioduchowska [14], internal dialogue is less varied in women with *anorexia nervosa* than in women without eating disorders. Their dialogue is dominated by rumination, persistence in disease, and dissociation, which are all detrimental to healthy functioning. These data correspond with narrative therapy approaches to anorexia [15–16], which describe the disorder as a "dominant story" that dictates the patient's life ("domineering voice").

Externalizing techniques are one of many detailed strategies used in transforming the story of the disorder that stifles patients' lives into a story that fosters their health and well-being. Externalizing techniques allow the patients symbolically convey, personify and actively communicate with the selected problematic aspects of their lives. Some of the basic virtues of externalization are that it promotes the ability to separate the person from syntonically experienced (especially in anorexia) symptoms of the disorder and facilitates the process in which the patients learn active ways to say "no" to the domineering voice of their disorder [17–19]. Those researchers who are skeptical about externalization [20–22] tend to emphasize the negative implications of attributing a separate "identity" to *anorexia nervosa*. There is a risk that the condition may gain too much autonomy and the patients will show a tendency to self-blame for not being able to meet their personal responsibility for recovery. Black-and-white thinking and the idealization of what we call "True Self" can also have a negative effect on the patients. Externalizing methods in psychotherapy should be used and scrutinized carefully. Further research on the subject is also required.

One of the methods to stimulate internal dialogue with the disorder is to write a letter [23–24] which the patient sends to her imaginary reader, namely – personified *anorexia nervosa*. Internal dialogues that occur between the healthy and the disordered part of the patients' Selves are also scrutinized in detail in the paper. We were also curious if and how the authors of the letters address a part of their Selves that hinders or ever prevents them (and their nearest and dearest) from healthy functioning. Our particular goal was to find out which type of positioning they adopt ("above"/"below").

We have developed our own system of categories based on constructivist-narrative approaches with particular emphasis on autobiographical narrative patterns [25] and

Dialogical Self Theory [26–29]. Three qualified jurors adhered to the system while coding the textual material for further analysis. Empirical data obtained in the research subsequently underwent semantic and frequency analysis.

Material

The research was carried out to perform the retrospective analysis of textual products provided by 40 patients (treated in the years 2009–2016), aged 11–25, from the Children's Psychiatry Ward and Mental Health Clinic at the Saint Louis Provincial Specialist Children's Hospital in Krakow. The textual products were designed as letters to their own disorder, i.e., *anorexia nervosa*, written according to the instructions adherent to narrative therapy. The material was interpreted with reference to personal details provided in the medical histories of the patients.

Method

A mixed qualitative-quantitative method was used in the analysis and interpretation of the textual material obtained in the study. The quantitative data were examined using hierarchical cluster analysis (Ward's method). The qualitative data were scrutinized with semantic categories using our own set of tools developed specifically for the research. The analytical categories were identified based on the general overview of the material with particular emphasis on the following structural properties: 1) the length of the letters and their emotional tone; 2) the adherence to the instructions and the type of motivation to accomplish the task; 3) textual mode (description/monologue/dialogue). The content of the letters was analyzed with regard to: 1) the reference the authors made to their own Selves (how they assessed and expressed themselves as heroes of their life stories; self-assessment and self-expression being the two leading elements in their autobiographical narrative patterns); 2) their attitudes to anorexia as a personified reader of their letters, analyzed with You-hero (friend vs. foe) and You-function subcategories (benefit vs. loss). The outcomes of the analysis served as a starting point to identify the types of internal dialogues that prevailed in each patient's story. This was subsequently used to categorize the type of positioning towards the disorder that was expressed in each letter (a relationship between the author and the reader of the letter). The way the patients generally positioned themselves towards the disorder (3) was used to describe each patient and to compare them with the rest of the sample.

Results

The outcomes obtained in the study are described using two major categories for textual analysis: statistical analysis and semantic categories applied by qualified jurors.

Statistical analysis

Hierarchical cluster analysis was used to identify two groups of patients who position their Selves towards the disorder in two different ways. Patients in Cluster 1, who account for 72.5% of the sample (see the dendrogram designed with Ward's method, Table 1), tend to dominate the disorder or position themselves above it ("above-positioning"). By contrast, patients in Cluster 2 (27.5% of the sample) increasingly more often position their Selves below their personified condition ("below-positioning"). Subsequent analysis demonstrates that the two types of positioning correlate with the following semantic categories (for a more detailed representation see Table 2):

1. Internal dialogues are more varied in Cluster 1 patients;
2. Internal dialogues in Cluster 1 patients are focused on: persistence in recovery (93.1%), dissociation (82.8%), identity (75.9%), and rumination (20.7%). Internal dialogues in Cluster 2 patients are in turn expressive of: persistence in disease (63.6%), identity (54.5%), rumination (36.4%), and, surprisingly, persistence in recovery (9.1 %);
3. Both Cluster 1 and Cluster 2 patients position themselves in ways that are equally contradictory: in Cluster 1 "above-positioning" (100%) coexists with "below-positioning" (72.4%), whereas in Cluster 2 the dominant "below-positioning" (90.9%) coexists with the "above-positioning" (9.1%);
4. Cluster 1 patients use more complex autobiographical narrative patterns in their letters, which is reflected in the clarity of their self-perceptions as agents of their own biographies (Cluster 1: 75.9%; Cluster 2: 27.3%), their self-awareness (Cluster 1: 93.1%; Cluster 2: 81.8%) and the vision of their goals and tasks (Cluster 1: 43.4%; Cluster 2: 9.1%). Cluster 2 patients are more aware of potential threats to their life goals and treatment process (44.8%) than Cluster 2 patients (0%); they also know more coping strategies (Cluster 1: 13.8%; Cluster 2: 0%);
5. Cluster 1 patients are more aware of the losses they suffered as a result of the disease (1 – 100%; 2 – 72.7%). They are more likely to describe the disorder as their "enemy" (1 – 100%; 2 – 63.6%); at the same time, they realize they derive certain benefits from the disease (1 – 86.2%; 2 – 90.9%) and remember cases when they treated it as a friend (1 – 51.7%; 2 – 54.5%).

Cluster 1 patients are aware they can fall back on both external (55%) and internal resources (72.4%,). By contrast, Cluster 2 patients report having no internal resources to rely on. They are also less likely to elaborate on their external resources (27.3%) despite the real social support they receive.

Table 1. **Dendrogram representing the outcomes of hierarchical cluster analysis using ward's method**

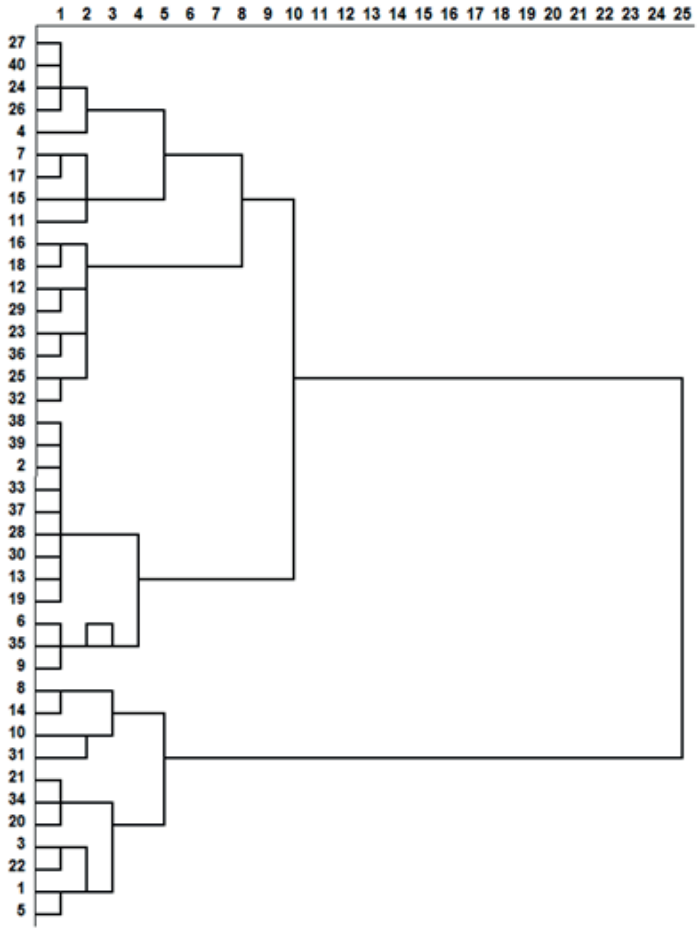

Table 2. **Self Positioning and selected semantic categories, statistical analysis**

Description		Total		Cluster 1		Cluster 2	
		Number	Percentage (n=40)	Number	Percentage (n=29)	Number	Percentage (n=11)
AU (Author of a letter)	positive assessment	14	35.0%	12	41.4%	2	18.2%
	negative assessment	26	65.0%	18	62.1%	8	72.7%
	WB-1	25	62.5%	22	75.9%	3	27.3%

table continued on the next page

AU (Author of a letter)	WB-2	36	90.0%	27	93.1%	9	81.8%
	WB-3	13	32.5%	12	41.4%	1	9.1%
	WB-4	13	32.5%	13	44.8%	0	0.0%
	WB-5	4	10.0%	4	13.8%	0	0.0%
	ZW	21	52.5%	21	72.4%	0	0.0%
	ZZ	22	55.0%	19	65.5%	3	27.3%
TM (textual mode)	D (description)	3	7.5%	1	3.4%	2	18.2%
	MAD (monologue and/or dialogue)	37	92.5%	28	96.6%	9	81.8%
TO (task-oriented)	IM (internal motivation)	23	57.5%	16	55.2%	7	63.6%
	EM (external motivation)	16	40.0%	10	34.5%	6	54.5%
RE (Reader)	Foe	36	90.0%	29	100.0%	7	63.6%
	Friend	21	52.5%	15	51.7%	6	54.5%
	Profit	35	87.5%	25	86.2%	10	90.9%
	Loss	37	92.5%	29	100.0%	8	72.7%
RL (Relationship Between Author and Reader)	I (Identity)	28	70.0%	22	75.9%	6	54.5%
	P1 (Persistence in Recovery)	28	70.0%	27	93.1%	1	9.1%
	P2 (Persistence in Disease)	13	32.5%	6	20.7%	7	63.6%
	R (Rumination)	19	47.5%	15	51.7%	4	36.4%
	D (Dissociation)	24	60.0%	24	82.8%	0	0.0%
	AP (Above-Positioning)	30	75.0%	29	100.0%	1	9.1%
	BP (Below-Positioning)	31	77.5%	21	72.4%	10	90.9%

Semantic categories

Semantic analysis focused on two basic issues: the formal structure of the letters and their content. The structural differences between the letters written by patients who either dominate or are dominated by their disorder (which indirectly indicates the degree of their narrative experience structuring) are as follows: the length of the letters and the way in which they use particular elements of their autobiographical narrative patterns.

The length of the letters ranges from 4 to 1432 words ($M = 345$). The mean length in Cluster 1 ($M = 371$) is nearly one hundred words longer that in Cluster 2 ($M = 275$).

Due to the limited available space, only selected semantic categories were represented in Table 3.

Table 3. **Textual Representations of selected structural and semantic analytical categories**

Semantic Categories	Examples
Structural Categories Motivation to Task	
– internal	–"This is an opportunity to think about things that I tend to avoid thinking or talking about. That's about you, Anorexia, […] to realize when we first met…" [Letter No. 13]; –"I've got it! I do remember now…" [Letter No. 1]
– external	– "[…] this is my <homework> from my therapist. I don't like the whole idea really, but there's nothing I can do about it." [Letter No. 1]
Semantic Categories Internal Dialogue Types:	
– identity	– "I don't know if I'm going to be like I used to be" [Letter No. 19]; – "What is it that we're looking for really?" Happiness? Love? Self-awareness?" [Letter No. 16]
– persistence in recovery	– "I was wondering" if you'd reply and what it would be" [Letter No. 14]; – "[…] I have to overcome a barrier which I have already broken down to some degree, but there is still some work to be done. I have to do it now. This is my life and I am responsible for it" [Letter No. 16];
– persistence in disease	– "There is something I like about you" [Letter No. 15]; – "I don't want to fight with you because otherwise I would have to gain weight, which is the last thing I want to do" [Letter No. 21];
– rumination	– "[…] I am bothered about my eating or not eating all the time" [Letter No. 39]
– dissociation	– "Just leave me be. Get off my back!" [Letter No. 2]; – "The only thing you gave me was an illusory sense of control. Do me favor. Vanish!" [Letter No. 7A] – "There is nothing I could tell you […]. Stop […]. I don't want you in my life!!!" [Letter No. 39]

Discussion

The outcomes of the research correspond with empirical data and clinical observations suggesting that patients diagnosed with *anorexia nervosa* have a lower ability than their health controls to adopt various types of positioning in their internal dialogues. They also seem to confirm narrative patterns that are typical of patients with *anorexia nervosa* and that have been reported in the literature on the subject. Ruminative and dissociative dialogues prevail in their narratives. The patients who were defined in the

research as "dominated by their disorder", demonstrated lower internal dialogue levels. Their dialogues were dominated by rumination, persistence in disease, and identity. The dialogues of the patients who adopted the "above-positioning" were leaning more towards identity, persistence in recovery, and dissociation.

Dissociative dialogues undoubtedly indicate that Cluster 1 patients have made an attempt to disassociate themselves cognitively and emotionally from the disorder in order to relatively detach from it. The patients demonstrate strong ambivalence, which in our opinion suggests that they are going through the process of constructing a more complex and narratively structured Self. Despite the fact that, when compared with their healthy controls, Cluster 1 patients demonstrate a number of deficiencies in self-awareness and health-promoting self-control, they differ greatly from Cluster 2 patients in these two categories. Patients with a tendency to adopt the "below-positioning", lack clarity in representing themselves as the agents of their own biographies and the ability to identify goals (other than weight control), together with the ability to imagine potential threats to reaching these goals.

One of the most prominent parameters that sets Cluster 1 and Cluster 2 apart is the proportion in their respective perceptions of benefits/losses to be derived from the disorder and difficulties in using a future-oriented time perspective when thinking about the disorder (ruminative reminiscing on a "life-giving" friendship with the disorder as a means to satisfy their essential needs). Cluster 2 patients also stand out as utterly devoid of any internal resources that are necessary to cope with the disorder.

Conclusions

Postulated in the Dialogical Self context, supporting internal dialogue in patients with *anorexia nervosa* seems to co-exist with subsequent stages in the treatment process, which is reflected in the letters to anorexia written during therapy. A reverse correlation can also be surmised – the positive effect of the intentional therapeutic triggering of internal dialogue and narrative experience structuring using narrative stimuli such as letters [30]. The outcomes allow for distinguishing two groups of patients with anorexia nervosa who differ primarily in their attitudes towards their own illness (notwithstanding the fact that both groups, as they wrote their letters, were in therapy for a similar period of time). Assumedly, each group should be offered a different method of therapy. The above hypothesis may be verified if the process of psychotherapy is continued. For this reason, we believe it is worth continuing empirical research and clinical observations to assess the diagnostic and therapeutic potential inherent in the tools that encourage patients with *anorexia nervosa* to externalize their experience.

Research-wise, it is postulated that factor analysis is carried out further using the outcomes obtained on larger research samples. This may help define deeper (latent)

structures of each coexisting dimension of psychological functioning and their respective influence vectors in the patients. Preliminary research hypotheses can be made concerning degrees in autobiographical narrative pattern development and their impact on the recovery process. Letters written to one's own personalized condition can serve as a useful auxiliary diagnostic tool to describe previously discovered textual categories as indicative of the type and degree of motivation for recovery, as well as defining the individual illness experience patterns in the patients.

Concurrently, the outcomes can be used to improve externalization techniques in therapy and prevention: letters to anorexia can be written according to different instructions that are suited to different "patient types" as well as the stage and type of therapy they are in; at the same time, the instructions can be sensitive to potential threats inherent in using externalization techniques with psychotic patients.

Also worth noting is the suggestion to combine various activities (e.g., letters to different recipients or letters designed as third person narratives) and monitoring the process of multiple letter writing, which improves the narrative structuring of individual experience of the patients.

Institutions involved in the study:
– Department of Psychology, Pedagogical University of Krakow, ul. Podchorążych 2, 30-084 Krakow.
– Children's Psychiatry Ward and Mental Health Clinic at the Saint Louis Provincial Specialist Children's Hospital in Krakow, ul. Strzelecka 2; 31-503 Krakow.

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Address: Urszula Tokarska
Human Development Support Psychological Unit,
Department of Psychology, Pedagogical University of Krakow
30-048 Kraków, Podchorążych Street 2