Body Image and Social Media:
An Adlerian Approach to Decoding the Mind
A Literature Review
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Abstract

Body image and social media change over time. Although cultural ideals have always been able to shape and influence the public’s perception, the ideal body type has become more unattainable due to technology and the ability to digitally edit an individual’s physical characteristics. As adolescents grow and mature, they develop a desire for a sense of belonging with peers and the community. Frequently, parents have a difficult time understanding an adolescent’s perception of his or her body image. It is even more difficult for parents when they attempt to raise adolescents in conjunction with significant media influence. The focus of this project is to combat the thin, ideal body image portrayed in social media. Specifically, through the lens of Adler’s Individual Psychology, mistaken beliefs, private logic, and the social life task are reviewed to combat social media’s grip on body satisfaction among adolescents. Through the outlined group process, mental health practitioners could include mindfulness techniques, introduce Adlerian concepts, and use narrative therapy to assist adolescents struggling with eating disorders in the creation of a new, preferred life story.

Keywords: social media, adolescents, body image, eating disorders
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“The thing to do, it seems to me, is to prepare yourself so you can be a rainbow in somebody else’s cloud. Somebody who may not look like you. May not call God the same name you call God – if they call God at all. I may not dance your dances or speak your language. But be a blessing to somebody. That’s what I think”

–Maya Angelou
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Body Image and Social Media: An Adlerian Approach to Decoding the Mind

The purpose of this paper is to demonstrate the link between social media and adolescent body image issues. With an increased awareness of the connection between eating disorders and social media, parents and therapists could recognize the implications of social media influence and discover potential treatment options.

The unavoidable social life task is in direct contact with social media and the thin ideal (Dittmar, 2009). Adolescents do not possess adequate self-awareness to understand the connection between social media and the thin ideal. The unobtainable thin ideal is projected in magazine images, air brushed images on social media, and the dolls young children play with (Dittmar, 2009). According to Dittmar, the adolescent’s social task and thin ideal become unattainable and could lead to an eating disorder. Exposure to social media images activates and highlights an individual’s bodily self-concept which could cause negative distress and body dissatisfaction (Dittmar, 2009).

Research shows that narrative therapy, specifically narrative therapy and group work, will produce a higher success rate for adolescents as they discover triggers and identify private logic (Brown & Augusta-Scott, 2007). By empowering adolescents to recognize private logic, mistaken beliefs, and the impact of social media, adolescents could become better equipped to move forward to recovery. Additional research is recommended to raise awareness of the triggers associated with eating disorders and social media.

Eating Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders, eating disorders wreak havoc on the body and its organs (5th ed; DSM-5; American Psychiatric Association, 2013). Eating disorders can occur with men or women, and an eating disorder is not limited to a
certain age. There are four main eating disorders recognized by the DSM-5 (American Psychiatric Association, 2013). According to the National Eating Disorders Collaboration, eating disorders include: other specified feeding and eating disorders (OSFED), bulimia nervosa, binge eating disorder, and anorexia nervosa (as cited in American Psychiatric Association, 2013).

For the purpose of this project, two common eating disorders will be referenced. The two most common eating disorders are bulimia nervosa (bulimia) and anorexia nervosa, or anorexia (American Psychiatric Association, 2013). According to Hudson, Hiripi, Pope, and Kessler, (2007), “lifetime prevalence estimates of DSM-IV anorexia nervosa, bulimia nervosa, and binge eating disorder are .9%, 1.5%, and 3.5% among women, and .3% .5%, and 2.0% among men” (p. 348).

Bulimia is characterized by eating large amounts of food within a short period of time or feeling loss of control when eating (American Psychiatric Association, 2013). This eating behavior is followed by a period of “purging” where the client rids the body of the food through vomiting, the use of laxatives, or both. In accordance with the DSM-5, bulimia nervosa can be characterized and diagnosed by physical and psychological signs. The physical signs of bulimia could include a change in weight (gain or loss), signs of damage to the inside of the throat, mouth, teeth, and gums, fainting, dizziness, bloating, and feeling tired. (American Psychiatric Association, 2013). Psychological signs include, but are not limited to, preoccupation with eating, a distorted sense of body image, sensitivity to comments about body image and/or food, depression, anxiety, and irritability (American Psychiatric Association, 2013).

Anorexia nervosa is less about a loss of control and more about controlling the body (American Psychiatric Association, 2013). Anorexia is usually defined and diagnosed when a
client imposes an extreme restriction to his or her food and energy intake (American Psychiatric Association, 2013). Similar to bulimia, the client will have a disturbed body image; however, anorexia nervosa includes an intense fear of gaining weight and being overweight. Physical signs of anorexia nervosa could include a drastic loss of weight, feeling tired, appearing malnourished, loss of hair, very low energy, and feeling cold much of the time. When people struggle with anorexia nervosa, psychological symptoms include strict control of food intake (e.g., counting out very strict calories or skipping meals), intense fear of weight gain, reduced capacity for thinking, low self-esteem in combination with a perfectionistic attitude of the self, rigid thoughts about food, and the inability to maintain a normal body weight for the person’s age and height (American Psychiatric Association, 2013). According to the DSM-5, anorexia and bulimia represent public health concerns and they are frequently associated with other disorders such as depression and anxiety (American Psychiatric Association, 2013).

**Social Media and Body Image**

According to the Miriam-Webster Dictionary, social media is defined as forms of electronic communication (such as websites for social networking and microblogging) through which users create online communities to share information, ideas, personal messages, and other content such as videos (“Social Media,” n.d.). Social media first appeared in popular culture in 2004 and is a “toxic mirror” in the hands of adolescents (Simmons, 2016, para. 1). According to Kilbourne (1999), mental health professionals in eating disorder centers see the impact of social media on the patients. Kilbourne (1999) suggested that social media is a controversial topic because some mental health professionals believe social media has a direct impact on adolescents, and other mental health professionals do not believe this is true. Eckstein and Baruth (1996) stated some professionals believed eating disorders were a typical social issue that
did not involve technology. Similarly, Holmstrom (2004) found that some mental health professionals considered personality traits and family environment of greater importance and did not believe there was a direct link between social media and body dissatisfaction.

Adolescent boys and girls are maturing with an abundance of technology. Most adolescent lives are filled with various forms of social media (e.g., advertising and marketing, accessible websites such as Instagram, Facebook, Musical.ly, YouTube, and Podcasts from various sources). As children enter middle school, they receive chrome books and tablets that are meant to supplement learning and the ability to learn on the internet. Young teens are moving from a previous two-prong approach of nurture and nature to a three-prong approach that includes the influence of social media (Derenne & Beresin, 2006). Pixels and codes flash before the adolescent’s eyes, and the brain begins to think that those images, words, and videos are no longer an alternative reality (Markey & Markey, 2012). Additionally, this marketed reality becomes a part of the adolescent’s mind, body, and soul.

According to the National Eating Disorders Collaboration, body image disorders are defined as a preoccupation with perceived flawed physical features though this is not apparent or a matter of concern to objective observers (American Psychiatric Association, 2013). Body image is no longer a symptom of an air brushed magazine ad (Markey & Markey, 2012). For instance, Markey and Markey suggested that body image was warped by unattainable notions of money, power, status, and photo filters. Today, an adolescent’s self-worth could be determined by a 140-character tweet on Twitter that continues on even if the tweet is deleted (Markey & Markey, 2012).

According to Spettigue and Henderson (2004), the media’s role in body dissatisfaction is well studied. In fact, research documented “increasing thinness in Playboy centerfolds, Miss
America Contestants, and fashion models between the 1950s and 1990s” (Spettigue & Henderson, 2004, p. 16). A direct link existed between actual body size and the “media ideal,” and an increasing difference could be linked to an increase in body dissatisfaction.

Spettigue and Henderson (2004) stated media pressure created in advertising on television, in magazines, and other media outlets “…glorify a slender ideal” and over emphasize the importance of body image (p. 16). Moreover, Spettigue and Henderson’s research underscored the importance of creating body dissatisfaction to supplement the burgeoning beauty industry. In 2002, Groesz, Levine, and Muren conducted a meta-analytical study to determine the effect of mass media and the ability to create a slender ideal which in turn has an impact on pre-existing body image concerns in adolescent girls. Groesz et al. (2002) examined 25 empirical research studies and compared selected methodologies, age of participants, and the number of stimuli introduced in each study. Groesz et al. concluded that there was a direct link between media images and body dissatisfaction among vulnerable adolescents.

Groesz, et. al. (2002) further noted that body image was viewed far more negatively after the participants viewed thin media images (compared to viewing average size media images). Participants reacted to images of models and their body types; however, the participants also reacted to images of inanimate objects that were either slender or plump in shape. The thin ideal is conveyed and reinforced by many social influences, including family, peers, schools, athletics, business, and health care professionals (Levine & Smolak, 1996). Groesz, et al. (2002) noted that the largest contributor to social media influences tends to be mass media. Mass media could include technologies, billboards, radio, magazines, and television. Groesz et al. discovered that mass media promoted, if not established, a standard of the thin ideal for females that contributed to negative body image. Groesz et al. discovered that social media had the greatest impact on the
body image of participants age 19 years or younger. Social media had a greater impact on adolescents compared to other groups of participants in the reviewed studies. Groesz et al. concluded that a direct correlation existed between social media and body image.

Adolescents tend to be extremely vulnerable to social cues, what friends think and do, and how they are perceived by peers at school (Ferguson, Munoz, Garza, & Galindo, 2013). According to the DSM-5, the typical age of onset regarding body image disorders is between 12-13 years of age with an average onset of 16-17 years of age (American Psychiatric Association, 2013). Ferguson et al. (2013) established a noteworthy relationship between media ideals and an adolescent girl’s body displeasure. This line of research suggests that it is worth considering the potential negative impact of social media among adolescents. For instance, adolescent fashion magazines showcase thin, lean women and muscular men. Adolescents may view these images and bodies as the ideal (Gondoli, Corning, Salaffia, Bucchianeri & Fitzsimmons, 2011). As a result, adolescents may want to look like the magazine models because they believe it will help them become more popular and desired, increase the number of friendships, and help them become more successful.

The pressure to be thin may be one of the largest predictors of body dissatisfaction among adolescent girls (Gondoli et al., 2011). The combination of the pressure to be thin, along with pressure from peers, has an impact on body image. According to Ferguson et al. (2013) the catalyst model suggests that adolescent peer pressure may have the greatest influence on body image. The purpose of the catalyst model is to analyze the degree of correlation between themes of aggression (i.e., peer pressure and media sources) with real-world consequences (Surette, 2013). According to the catalyst model, violent tendencies and behaviors toward oneself arise
from a combination of genetic and early social influences—especially the influence of family and peers.

Grabe, Ward, and Hyde (2008) conducted a meta-analytical review of 77 studies intended to examine the growing body image concerns among adolescents and young women. The purpose of this meta-analytical review was to understand why (regardless of body size) so many adolescent girls are dissatisfied with their bodies. Grabe et al. discovered body dissatisfaction had an impact on up to 50% of girls and young women (p. 6). Rather than blaming the media, it may be that the media is simply showing society what it wants to see (Ferguson et al., 2013).

Research with preadolescents is less extensive, yet it is clear that by age 3, children have a negative view about being overweight (Grabe et al., 2008).

Ferguson et al. (2013) wanted to extend the discourse regarding the influence of social media, family environment, and personality characteristics on body image issues in young girls and women. The researchers hoped to correlate the “…influence of peer and media effects on girls’ body dissatisfaction, eating disorder symptoms and life satisfaction” (Ferguson et al., 2013, p. 1). Ferguson et al. concluded that social media had an influence on adolescent body image satisfaction. In addition, peer groups had a significant negative impact on adolescents.

Professionals are starting to research and take note of media influences on body dissatisfaction as it relates to eating disorder symptoms (Becker, Burwell, Herzog, Hamburg, & Gilman, 2002). Becker et al. concluded body dissatisfaction and eating disorder diagnoses are on the rise in Western nations. Becker et al. researched the correlation between Western television images and the adolescent’s view of the self and body image. Becker et al. compared Fiji eating disorders before the arrival of television and after the arrival of television. Prior to 1995, there was one case of anorexia nervosa (Becker et al., 2002). In 1998, anorexia had risen
from 0% to 69%, and the younger generations routinely noted the appearance of attractive actors on television shows like *Beverly Hills 90210* and *Melrose Place* as a reason for the sudden poor body image (Becker et al., 2002). “For the first time, inhabitants of the island began to exhibit disordered eating” (Becker et al., 2002, p. 510). Through the addition of television and media, the complete societal order of Fiji changed and inhabitants began to compare the bodies of celebrities on television with the bodies they saw in the mirror. According to Becker et al. (2002), simply viewing television imagery had a distinct negative impact on body awareness and body image status among peers. Adolescent girls began to wonder if they would be accepted in Western society if they became part of the Australian community (Becker et al., 2002).

In the current media culture, most adolescents are unaware that magazine photos are airbrushed and that there are computer programs that remove blemishes. Instead, adolescents see stunning actors and actresses on the red carpet in gowns and suits. What they do not realize is that these celebrities have personal trainers, endure fasting, and have undergarments that flatten stomachs to enhance the look of tight-fit clothing (Derenne & Beresin, 2006). Young men and women do not see this side of the highly publicized and photographed fashion soiree. Instead, they see the final product on television or in a magazine and they think this is the way they should look. As a result of television, actors, and magazines, adolescents may believe they need to do more and that they are not as thin as they should be. An example of this influence is the highly publicized bodies and low weight of fashion models. Kilbourne (1999) noted that “Twenty-five years ago, the average fashion model was 8% thinner than the average woman. Today, that number has risen to 23%, likely reflecting the combination of rising obesity rates in the general population and progressively thinner ideals (p. 6). Kilbourne suggested that from the beginning of life, most individuals have rooted within them, whether by choice or influence, the
concept of achieve, arise, and conquer. That is, there is a constant desire or longing to be perfect at something. Because perfection does not exist, individuals lack fulfillment and the longing for perfection continues (Ansbacher & Ansbacher, 1956).

A juvenile’s body image is hard for a parent to understand, but it is even more difficult for parents to navigate through this issue. Dittmar (2009) revealed how the thin ideal in social media has a negative impact on body image. Dittmar stated body image and dissatisfaction developed as an essential aspect of mental and physical well-being. Due to this finding, it is critically important that parents, and those in parental roles, unite to recognize social ideals before eating disorders become a greater epidemic. Dittmar stated people may not be aware of body perfect ideals because they are thought of as social norms. Dittmar (2008) reported “body perfect ideals are communicated early to children, for example through dolls such as Barbie, and girls as young as 5 to 7 years reported lower body esteem and a greater desire for a thinner body directly after exposure to such doll images” (p. 285).

Prior to social media, body image was determined by various factors including politics and media (Derenne & Beresin, 2006). Derenne and Beresin found that “our nation’s health has reached a point of crisis” (p. 258). For instance, according to the American Obesity Association, in 2006, 65% of adults and 30% of children were overweight (as cited in Derenne & Beresin, 2006). Additionally, 30% of adults and 15% of children met the criteria for obesity. One explanation for the increase in weight may be that children rarely play outdoors. Instead, children spend the day online or in front of the television while snacking on nutritionally empty foods. According to the American Obesity Association, children will typically spend one hour each day on homework and four hours watching television (as cited in Derenne & Beresin, 2006). Similarly, parents spend less time outdoors or engaging in activities that typically
contribute to a healthier lifestyle. Children tend to mimic the behaviors of parents and consider this normal social behavior (Derenne & Beresin, 2006). For example, if a parent eats unhealthy food and watches television, the child will engage in similar behavior to bond with the parent. Instead, if a parent chose to be outside walking, running, hiking, or playing yard games, then the child would be more likely to follow the example and continue that activity level into adulthood. According to Derenne and Beresin, this is especially true when activities lead to significant memories and happy bonding moments between the parent and the child.

Derenne and Beresin (2006) found that when children are exposed to an abundance of movies and technology (e.g., TV, Facebook, Kindles, Tablets, YouTube and multiple social media platforms), they are at a higher risk of obesity. Derenne and Beresin stated it was the type of exposure (not the amount of exposure) that was associated with poor body image. For example, if the child and parent watched athletically challenging television shows, and children were inspired to try those activities, the risk of obesity would decrease because the child would see the value of a healthy body and mind. On the other hand, if the child and parent typically watched shows that positively celebrated unhealthy and morbidly obese individuals, children may begin to believe obesity is normal. While the television show encourages a positive outlook and a confident body image, it portrays a lifestyle filled with poor health choices.

Derenne and Beresin (2006) suggested that the rise of reality television has an impact on body image. For example, reality shows such as Dr. 90210 and The Swan promote dieting, plastic surgery, and complete makeovers of average people in an attempt to create a better version of the individual. Although some criticized these shows for the way they promoted the ideal body image, the shows were very popular. The contestants endured body augmentation and a very intensive diet plan prior to revealing the “new” person in the final episode. Derenne and
Beresin (2006), found that this type of media consumption fostered the belief that people could not achieve their best self under natural conditions. Additionally, when children watched shows like this, it contributed to the increase in childhood depression rates. Hill, Draper, and Stack (1994) found that “as highlighted in a Newsweek article, classic eating disorders such as anorexia and bulimia are being diagnosed at younger ages (some as young as eight or nine), and with higher frequency” (p. 5). In fact, “a 1994 survey found that 40% of 9-year-olds have been on a diet (Tyre, 2005, p. 1).

When parents monitor what a child watches on television, children can find other avenues to be exposed to social media and other factors that contribute to a negative body image. Pro-ana (pro-anorexia) and pro-mia (pro-bulimia) websites teach young adults how to be thin like their favorite celebrities or fashion models (Andrist, 2003). According to Andrist, some websites share images and pro-eating disorder propaganda and ask people to join their “life style choice.” People are encouraged to engage in eating-disordered behavior by posting messages detailing the weight loss progress. These websites provide tips, support, and reassurance that this is the ideal way of life for their readers. Andrist (2003) stated that pictures of emaciated women resembling concentration camp victims serve as “thinsperation.” Andrist believed the aforementioned websites can be detrimental to self-conscious adolescents struggling to be accepted by peers. For instance, when adolescents are bullied, or feel like outsiders, the people on this website provide a false sense of acceptance within the group by promoting eating disorders.

Derenne and Beresin (2006) stated adolescents see stories of easy plastic surgery fixes. One of the recent popular plastic surgeries is removal of the lower ribs (a rib resection) and adolescents can read about this surgery in magazines and watch it on reality television. This type of plastic surgery has been highlighted on television shows such as CBS Early Show, and
Previous celebrity rumors referred to Marilyn Manson and Kim Kardashian obtaining a rib resection (CBS News, 2017). Derenne and Beresin stated men and women with significant financial means have the ability and the desire to have ribs removed to decrease the size of the waist. Adolescents are not privy to such expendable cash resources, so they turn to other means of self-destructive behavior such as corsets and eating disorders to decrease the size of the body (Derenne & Beresin, 2006). These options are extremely dangerous with long-term consequences that could include painful health problems such as shortness of breath (which could lead to pneumonia) and dislocated visceral organs.

According to Mabe, Forney and Keel, 2014, “With 655 million users daily, Facebook represents a ubiquitous merging of two social influences linked to risk for developing eating disorders through reinforcement of the thin ideal: media and peers” (p. 516). For example, Tiggerman and Slater (2013) found that when adolescent girls had a Facebook account they were more likely to suffer from an internalization of the thin ideal. Additionally, the girls displayed signs of body surveillance and all of the girls in the Facebook account group had an inner desire to be smaller and thin. Tiggerman and Slater suggested the negative exposure to the images and stories on Facebook, the number of “friends,” and the amount of time spent on social media was significantly linked to an increased body image disturbance.

Smith, Hames, and Joiner (2013) compared Facebook use vs. eating disorders and eating pathology among women. Smith et al. (2013) found that “Facebook use, defined as the tendency to seek out negative evaluations and/or engage in social comparisons, prospectively predicted greater eating pathology” (p. 238). This result highlighted the physiological effects of Facebook. Similarly, Mabe (2014) found that Facebook users experienced increased eating pathology and an increase, or maintenance of, an already established sense of body dissatisfaction. Mabe et al.
discovered that recurrent use of Facebook was associated with greater disordered eating. For example, Facebook users experienced greater anxiety regarding weight and body shape compared to alternate internet activity. Mabe et al. (2014) discovered,

Before the advent of social media sites, [society] was confronted with unrealistically thin images of beauty from magazines, films and television. [However, society was able to], also engage with peers who represented a full range of body weights and shapes in their immediate environment. Now, [society has] a constant and active space to engage in social comparison of peers who may simultaneously portray and reinforce the thin ideal. (p. 520)

For example, the default setting for Facebook allows anyone to “tag” another in a photograph. (Tagging is when a person uploads a photo and indicates who the people are in the photo.) Even if a person is not “tagged” in a photo, a photo could still be uploaded on an individual’s Facebook page. This photograph becomes available to be shared by anyone with access to an individual’s Facebook account. Sharing is when someone can take a photograph and either send it to others, or place it on their Facebook page where it can then be shared again. Setting options could give a person the option to approve the tag; however, in this case, even if the tag is not approved, the photo is still posted—just not directly linked to the person’s Facebook account (Mabe et al., 2014).

Mabe et al. (2014) pointed out,

[those with] greater eating pathology not only reported spending more time on Facebook, but also reported engaging in appearance focused behaviors, such as comparing their appearance to friends’ pictures and un-tagging photographs of
themselves, perhaps in order to remove unflattering photographs and minimize opportunities to become the target of downward social comparison. (p. 520)

Mabe et al. found that if an adolescent is tagged in an unflattering photograph, that photograph may be immediately shared and peers begin to leave comments. Additionally, it can be extremely difficult to remove or delete a photograph. Even if the photograph is removed, it is possible it was viewed, shared, and posted on other websites. Mabe et al. stated an adolescent’s self-image is dependent on how peers see them and what they say about the adolescent. Mabe et al. reported that when adolescents placed greater importance on Facebook responses (e.g., the number of “likes” elicited by the Facebook postings) those adolescents reported an increased rate of eating pathologies or eating disorders. Mabe et al. believed the increase in eating disorders among this group was due to constant comparison with peers via social media. For example, adolescents compared personal image, clothing, “friend” counts, and activities of others on Facebook.

Thompson and Stice (2001) researched the internalization of societal ideals of attractiveness within the realm of eating disorders. The thin ideal internalization commonly refers to the degree to which a juvenile will internalize and believe the societal definition of attractiveness and the willingness to engage in the behaviors that will highlight these ideals. That is, adolescents internalize images of other people to achieve a sense of significance. This process is referred to as social reinforcement. Specifically, family, peers, and media may strengthen the thin ideal body image through comments or actions that serve to maintain and perpetuate this ideal (Thompson & Stice, 2001).

Hohlstein, Smith, and Atlas (1998) proposed that young adolescents view “ideal” bodies in social media and this leads to body dissatisfaction. Additionally, body dissatisfaction leads to
diETING to achieve the ideal body shape and this could initiate an eating disorder. Thompson and Stice (2001) stated,

Dieting is theorized to result in a greater risk for bulimic symptoms because individuals might binge eat in an effort to counteract the effects of caloric deprivation. Finally, negative affect may increase the likelihood of bulimic symptoms because of the belief that eating provides comfort and distraction from negative emotions. (p. 181)

Adolescents begin to internalize the thin ideal which could contribute to the development of an eating disorder later in life (Stice & Agras, 1998). Stice and Agras suggested that awareness of the thin ideal increases the therapist’s ability to identify an eating pathology.

**Therapeutic Intervention**

When clients are diagnosed with anorexia or bulimia (American Psychiatric Association, 2013), mental health professionals can engage the client in a variety of treatment options. Therapists could work individually with clients, teach specific skills, or work through a specific therapeutic process.

**Individual Therapy**

During individual therapy, a client and therapist speak on a one-to-one basis. This type of individual psychotherapy is, “the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable” (American Psychiatric Association, 2013). Within the therapeutic sessions, mental health professionals incorporate various techniques and approaches to therapy. During individual sessions, therapists may support clients by improving coping skills or educating clients to increase personal knowledge of
a specific disorder. Therapists likely include various theoretical approaches and evidence-based therapeutic techniques during individual therapy sessions.

**Psychoeducation**

Psychoeducation is an evidence-based practice for clients and loved ones used to provide support and the understanding of necessary information to assist clients and families as they learn to cope with an illness such as an eating disorder (Hogarty, Anderson & Reiss, 1991). Psychoeducation can take place individually, or in a group setting. In group sessions, mutual support can play a large role in the healing process (Hogarty, et. al., 1991). In addition, therapists could consider a positive use of social media to facilitate the acquisition of information. For example, Brene’ Brown, one of the leading experts on shame and vulnerability, uses information on her website, TED talks, and YouTube videos to promote mental health and wellness (brenebrown.com). Through the process of psychoeducation, clients and families leave the therapeutic environment armed with the necessary tools to cope and achieve success (Hogarty, et. al., 1991).

**Dialectical Behavioral Therapy**

Linehan (1993) developed dialectical behavioral therapy (DBT) to assist clients with the development of core mindfulness. There are three positions of mind that remain in constant fluctuation: wise mind, logical mind, and emotional mind (Linehan, 1993). Linehan believed in the therapeutic value of increased awareness of feelings and the recognition of internal emotional states. Through the development of what skills, clients increase awareness of feelings and internal emotions. The core mindfulness what skills are: observe, describe, and participate. According to Linehan, (1993), “the goal is to develop a lifestyle of participating with awareness;
an assumption of DBT is that participation without awareness is characteristic of impulsive and mood dependent behaviors” (p. 12)

Dialectical behavioral therapy is designed to assist clients suffering from mood disorders (Linehan & Dimeff, 2001). Additionally, DBT is used for those who need to change patterns of unhelpful behavior. Linehan and Dimeff stated that through the use of DBT, clients increased emotional and cognitive awareness by learning the triggers that led to specific feelings. Linehan and Dimeff (2001), suggested therapists and clients could use DBT techniques and coping skills to avoid undesired emotional reactions. A DBT technique that is often used is body scanning. Mindfulness based stress reduction (MBSR) includes body scanning (Kabat-Zinn, 2013). In a mindfulness session, participants close their eyes to calm themselves and create awareness (Kabat-Zinn, 2013). Participants take a “tour of the body” and focus as they feel every part of the body, they are directed to let thoughts fade away. Participants will move from the feet to the head and continue the process for the entire body.

**Narrative Therapy**

Narrative therapy was created to empower clients and recognize that individuals possess a natural competence and ability to see life through a positive lens (The Dulwich Centre, 2015). Narrative therapy can be used individually, in a group setting, or during couple’s therapy. The unique goal of narrative therapy is to transform the effects of the client’s problem instead of trying to transform the person (White & Epston, 1990).

Within narrative therapy, the goal is for the client and therapist to externalize the problem (Brown & Augusta-Scott, 2007). Brown and Augusta-Scott stated through *externalization* of the problem, the problem is viewed as an object (Brown & Augusta-Scott, 2007). Externalization demonstrates to the client “the person is not the problem, the problem is the problem” (White &
According to Brown and Augusta-Scott (2007), a narrative therapist will assist the client in the creation of helpful stories about themselves and their identities. For instance, through a discussion about the client’s story, a narrative therapist can help a client identify personal values and create an inner knowledge to live by those values. As a result, the therapist and client co-author a new story (Brown & Augusta-Scott, 2007).

As narrative therapists work with clients, they help clients find sparkling life events (The Dulwich Centre, 2015). **Sparkling events** are times when something may have gone awry, but a positive outcome came from the situation or circumstance (The Dulwich Centre, 2015). Recognition of sparkling events helps the client recognize the ability to overcome something in the past and make it a positive memory. Sparkling events can be used to work through current or past problems. The final step in narrative therapy is to help the client find his or her preferred story. When others affirm the client’s story, the affirmation confirms possibilities for the client (Brown & Augusta-Scott, 2007). Herres et al. (2017) found less favorable outcomes when adolescents participated in treatment that included the internalization of symptoms; however, adolescents responded much more favorably when narrative therapy was used to externalize feelings.

**Group Therapy**

Brough (1994) stated group therapy is a form of psychosocial management where a small group of clients meet to interact and discuss problems with each other and the therapist. Brough (1994) found that loneliness and the lack of social interest may be alleviated through an Adlerian approach to group therapy. According to Brough, Adler’s concept of social interest could be applied to a group setting. During group therapy, clients engage in social interaction and support
one another. When individuals struggle with similar issues, group members understand each other and encourage a sense of belonging within the group (Brough, 1994).

**Narrative Therapy and Group Work**

According to White and Epston (1990), a narrative therapist understands that a person’s life is based on a personal story (or narrative). During a group session, a narrative therapist leads the group in a discussion to identify which events appear to stand out for group members (The Dulwich Centre, 2015). White and Epston (1990) suggested identification of fateful life stories was an important factor in narrative therapy group work. For example, fateful stories may stem from harmful or negative events in the individual’s life. White and Epston (1990) found that when group members identified fateful stories, the group members participated in the reshaping of the negative story by providing alternative suggestions and ideas to change the outcome of the story. As a result of the group process, group members obtained the necessary skills and confidence to rewrite past and future events.

**Individual Psychology**

According to Griffith and Powers (2007), Individual Psychology, also known as Adlerian psychology, is based on the assumption that all human beings are unique and possess a variant of human possibility in the approach to the problems of social living. Individual psychology includes a holistic approach to mental health and working with clients (Griffith & Powers, 2007). When Adler developed Individual Psychology, he saw the client as a whole and focused on the pre-adulthood of the person (as cited in Hoffman, 1994). According to Adler, an individual needs to confront societal, love-related, and vocational forces in order to understand the external factors that essentially shape personality (as cited in Hoffman, 1994). Hoffman stated Adler found individuals did not want to feel they were inferior to others or suffer from social
disadvantage. In addition, Adler believed individuals were healthier when they became aware of social interest.

Adlerian Individual Psychology includes an emphasis on the inclination towards social interest. Adler noted the impact of social interest on an individual’s mental health when he stated “one must sense that not only the comforts of life belong to one, but also the discomforts” (as cited in Ansbacher & Ansbacher, 1956, p. 136). According to Hoffman (1994), adolescence is an ideal time to develop social interest. In fact, Adler believed that insufficient social interest resulted in misled striving for superiority and possibly—psychosis (as cited in Hoffman, 1994).

**Mistaken Beliefs**

Dreikurs and Soltz (1964) stated when adolescents cannot achieve personal goals, the goals form mistaken beliefs. *Mistaken beliefs* are beliefs that are hardened in a child’s mind, but are mistaken or false because they were not formed in the correct or healthy context (Dreikurs & Soltz, 1964). Because of the mistaken belief, an adolescent may engage in negative behavior such as: attention seeking behavior (annoying or disruptive behavior), power struggles (anger, insistent attitude, or ungrateful emotions) and revenge (hurtful words and actions). Dreikurs and Soltz (1964) directed therapists to work with an adolescent in a non-shaming approach and to facilitate the disclosure of the mistaken belief. In addition, Dreikurs and Soltz (1964) encouraged therapists to work with the adolescent’s parents to recognize the meaning and significance of the mistaken belief.

**Mistaken beliefs and body image.** Markey and Markey (2012) stated cultural expectations and magazines have the greatest impact on an adolescent’s view of him or herself. If an adolescent developed a mistaken belief about his or her body image and self-worth, cultural expectations may reinforce this belief by encouraging a thin body that ultimately leads to
happiness. Additionally, Markey and Markey (2012), found that female adolescents placed a greater value on beauty than male adolescents. In 2009, super model Kate Moss discussed that she lived by a size-zero slogan and encouraged others to do the same (Loveys, 2009). Moss stated, “nothing tastes as good as being skinny feels” (Loveys, 2009, p. 2). Lovey noted, “Kate Moss has been accused of encouraging young girls to become anorexic after glorifying a 'size zero' slogan. Lovey believed Moss’ quote continued to be a watchword for millions of people that struggled with anorexia and bulimia. According to Lovey (2009) “nothing tastes as good as skinny feels” is believed to have originated from some early Weight Watchers members; however, the same quote is commonly used on numerous slimming websites and blogs around the world. Adolescents cannot join Weight Watchers on their own, so the popularity of this quote primarily resonated with adults. As discussed prior, parents have a large impact on a child’s body image (Lovey, 2009) and play a large role in combating eating disorder tendencies.

Davison and Birch (2001) reported that if parents are unaware of a child’s eating disorder tendencies, or if the parent has a poor body image and/or an eating disorder, the child’s eating habits are going to be greatly influenced by the parent’s eating habits. Similarly, Zametkin, Koon, and Klein (2004) stated parents may believe they are helping a child achieve a healthy lifestyle and shielding the child from potential obesity; however, parents can have a significant negative impact on a child’s self-image. Elliot, Goldberg, and Moe (2004) found that when an entire family attempted life style alterations, adolescents achieved more success incorporating the changes due to the support mechanisms that exist within family unit. To ensure a child develops a positive body image, Elliot et. al., (2004), encouraged an increased focus on living a healthy life-style and a decreased focus on body appearance or weight.
Derenne and Beresin (2006) believed healthier messages from popular media sources at school, online, on TV, and at home, would be conducive to a positive body image; however, the media is a formidable force, and media messages are unlikely to change without effort. Because of this resistance to change, parents must be the solid and safe place for children. Dereen and Beresin (2006) encouraged parents to talk to children about healthy body image. For example, parents must ensure open lines of communication so children feel comfortable discussing social and peer issues instead of relying on online sources to fulfill this need. In addition, parents must increase language awareness, promote health, nutrition, and physical activity, and monitor media exposure to promote positive self-esteem and positive beliefs.

**Private Logic**

Private logic can be defined as a person’s false line of reasoning arranged from private meaning (Dreikurs & Soltz, 1964). Private meaning is a person’s private and unique valuation of self, others, and the world, and what life requires of him or her (Dreikurs, 1964). Therapists would work with clients to uncover private logic, the meaning of this private logic, and the resulting impact on the client’s life (Dreikurs & Soltz, 1964).

In terms of social media and eating disorders, self-imposed restrictions are a large component of a client’s private logic; however, restriction is not just about control (Belangee, 2007). Belangee noted that when adolescents do not feel safe in the world and feel a lack of control, restriction may help them feel safe. Thus, when adolescents restrict, they gain a false sense of control and this establishes a routine. Belangee suggested that routines provide a sense of safety. Additionally, when an adolescent is focused on his or her eating disorder, restriction may be a compensation technique used to cope with feelings of subordination, loneliness, and inferiority (i.e. not feeling equal to peers).
If an adolescent is experiencing feelings of inferiority, he or she may mask those feelings and focus on eating disorder symptoms (Belangee, 2006). As a result, adolescents start to blame the eating disorder and not the catalyst for the disorder. Rather than focus on the reasons for the inferior feelings, the only focus is on the maintenance of beliefs and behaviors associated with the self-perceived image and worth (Belangee, 2006). Essentially, the adolescent begins to focus on this self-perceived image and worth until the self-imposed restrictions become a lifestyle conviction (Strauch & Erez, 2009). Once a restriction becomes a lifestyle conviction, the restriction could become a safeguard or form of protection.

**Encouragement**

Griffith and Powers (2007) suggested that through the process of encouragement, parents lay the foundation regarding confidence and acceptance of self. According to Adler’s theory of encouragement, the goal is to encourage an individual to triumph over feelings of inferiority. Adler stated that feelings of inferiority are rooted in an adolescent’s experience with weakness, helplessness, and dependency (as cited in Griffith & Powers 2007). Once these feelings occur, they are then intensified by comparisons to siblings, parents, and adults. Adler believed feelings of inferiority led to the creation of a fictional final goal which promised a sense of relief from inferiorities, security, and success in future years. For instance, the greater the insecurity, the greater the fictional goal that contributes to a pattern of behaviors.

**Social Interest**

Adler (1931/1994) asserted that there are three “problems” or “life tasks” in an individual’s life: social, work, and love. The social task includes living as one with others. As noted by Ansbacher and Ansbacher, (1964), “We have always to reckon with others since we were born into a world of others, who are affected by our entering it and by everything we
choose or refuse to do in it, and on whose good will and comradeship we depend for our very existence” (p. 132). The work task involves the ability to live “on this poor earth’s crust,” made possible by the work of others and demands that we offer something in exchange (Ansbacher & Ansbacher, 1964, p. 155). Ansbacher and Ansbacher, (1964) stated the love task refers to every human being living as a “member of one of the two sexes and not of the other,” so he or she must meet the challenge of sexual cooperation, on which depends the future of humanity (p. 132).

Adler said:

Since we are born into a world of others: We always have to reckon with others, [others] are impacted by our entering it and by everything we choose or refuse to do in it, and on whose good will and solidarity we depend for our very existence. (as cited in Griffith & Powers, 2007, p. 37)

Adler, (1931/1994), stated that “as members of the human race, people exist as part of an association tied in with others around them” (p. 37). That is, innately, the human race is preconditioned to be like others and feel a connection to others. In terms of eating disorders, the focus would be on the social life task. An Adlerian therapist would encourage the development of social interest and facilitate a conversation about the reduction of mistaken beliefs (Adler, 1979). If the client developed positive social interest, the client could become better equipped to meet the immanent demands of society (Adler, 1979).

**Self-ideal within social interest.** According to Griffith and Powers (2007), “the self-ideal is an expression of the FICTIONAL GOAL of the personality, which is an image of success, and the organizing principle of the STYLE OF LIVING” (p. 99). When Adler (1979) began looking deeper into the self-ideal, he began to move away from common Freudian thought. Instead, Adler (1979) moved toward Vaihinger’s philosophy of acting *as if*. Vaihinger
argued that while sensations and feelings are real, the rest of human knowledge consists of "fictions" that can only be justified pragmatically (as cited in Honderich, 2005, p. 941). Vaihinger believed it was not worth asking whether things are true in an objective sense, since this cannot be discovered, but that one should ask whether it is useful to act 'as if' they were true (as cited in Honderich, 2005, p. 941). Vaihinger conceded that the concept of acting as if varied depending on the type of truth, which may be logical, scientific, religious, or something else (as cited in Honderich, 2005). Vaihinger’s philosophy gave Adler a diagram to interpret ideas and images of the future. For example, in the present moment, the images and ideas become a guideline, point of orientation, and act as compensations for childhood feelings of feebleness and incompleteness (Griffith & Powers, 2007).

The construct of internalizing the thin ideal can be understood in identity-related terms as the extent to which an individual incorporates the sociocultural “body perfect” ideal (Dittmar, 2009). Of crucial importance is the extent to which “body perfect” media ideals become such a central aspect of personal identity. Cafri, Yamamiya, Brannick, and Thompson (2005) proved the internalization of the thin ideal presented a crucial risk factor in the development of body image concerns and eating disturbances.

According to Nauert, (2015), without a close group of friends, adolescents will do anything to be like the other people. Instead of separating from the group, adolescents will change to feel connected to the group. Nauert found that adolescents will prioritize desires of peers ahead of personal goals and thoughts. Consequently, when adolescents conform to social norms, this conformity can increase self-doubting and negative thoughts about the body. Nauert stated many times, adolescents rely on peers for advice regarding socially acceptable appearances and behaviors. Nauert thought this may be because adolescents believe adults
simply want to direct their actions instead of talking about the rationale and thoughts behind the actions. Adolescents develop a herd mentality to escape a system of control; however, in reality, herd mentality is characterized by a lack of individual decision-making or thoughtfulness that causes people to think and act the same as the majority (wisegeekhealth.com). Nauert (2015) suggested that adolescents believe they escaped control because they chose to be a part of the group or chose to act in alignment with the group. Nauert stated it is this exact sense of control that fuels an eating disorder. For instance, the adolescent has control over what, when, and how he or she might choose to eat. In some cases, this may be the only time the adolescent feels a sense of control.

When an individual struggles with an eating disorder, he or she may be classified as an introvert (Williams & Manaster, 1990). In addition, those with eating disorders may appear detached socially withdrawn. To define the social task, Eckstein and Baruth (1996) suggested therapists engage adolescents in a discussion regarding the level of connection with others. A therapist may ask questions about the number and type of friends, connections, and associations that the child has to the community and to peers (Powers & Griffith, 1987). Eckstein and Baruth (1996) noted that adolescents who experience difficulty with these questions, or social life tasks, typically displayed increased personal dysfunction. Eckstein and Baruth found that if adolescents did not have many friends, did not feel a part of the community or school, or spent time in isolation, they may have feelings of inferiority and poor self-image. Eckstein and Baruth stated the therapist should listen to examples of a typical conversation with peers to determine what appears to be the thoughts, behaviors, or interests of those peers. Strauch and Erez (2009) stated restrictive thoughts and behaviors describe how, in addition to common food and body
restrictions, people with anorexia have a tendency to use eating disorders as a tool, or an excuse, to restrict the ability to address the social task.

**Discussion**

Derenne and Beresin (2006) found professionals noticed intensified rates of anorexia nervosa and bulimia nervosa. Derenne and Beresin, stated that eating disorder clinics noticed a newer trend in the referrals of progressively younger clients and an increased number of male clients seeking treatment for eating disorders. In addition, there is a significant contradiction between society’s idealized rail-thin body image and the more typical American body. Derenne and Beresin, suggested these contradictions are becoming increasingly multifaceted and are likely to involve the interplay of media pressure (to be thin), family eating and exercise patterns, and a relative surplus of non-nutritious food. Derenne and Beresin, suggested that dietary restrictions led to a monotonous pattern of self-deprivation, which could result in bingeing, weight gain, and worsening self-image.

Bliss and Klein (1990) found that social media was a significant influence on the number of diagnosed eating disorders. In terms of obesity in adulthood, social media could be directly correlated to a previous childhood experience (Laser, 1984). Laser stated that in accordance with Adlerian theory, adolescents move through life toward an ultimate goal. Bliss and Klein (1990) suggested the adolescent begins to formulate life goals based on personal views about the self, the world, and how he or she might interact with parents, siblings, and peers.

As previously discussed, Bliss and Klein (1990) stated an adolescent’s goal completion is heavily influenced by overcoming a sense of inferiority. In addition, an adolescent begins to process his or her environment (i.e., the world) in an effort to establish a sense of belonging among peers and community. As a result of this sense of belonging, adolescents begin to move
toward a goal on the useful side of life. On the other hand, Griffith (1984) stated, “One example of the external expression of useless striving may be the surfacing of unconsciously motivated somatic symptoms, which eating disorders exemplify” (p. 439). Adler believed, “Man knows more than he understands” (as cited in Ansbacher & Ansbacher, 1956, p. 232). Therefore, it is important for a therapist to work with an adolescent to identify inferior feelings to avoid the potential for striving on the useless side of life (i.e., striving for superiority). If the therapist can uncover what the adolescent’s main unconscious goal would be, the therapist could facilitate a new understanding. This understanding would help the therapist and client co-author a new story so the adolescent could develop a healthy lifestyle and strive on the useful side of life.

Implications for Practice

Through a proposed 8-week closed group, up to 10 adolescent girls struggling with eating disorders will be exposed to Adlerian concepts (Griffith & Powers, 2007), dialectical behavioral therapy skills (Linehan, 1993), and narrative therapy techniques (White & Epston, 1990). Adolescent girls will develop an understanding of self, acquire necessary skills, and encourage one another to write a preferred and healthy life story (White & Epston, 1990). The group process will encourage a sense of belonging and through the process of identifying private logic and mistaken beliefs (Griffith & Powers, 2007), group members offer alternatives for a preferred life story (White & Epston, 1990).

Week one. During the first week of the group, the facilitator and participants begin with introductions. (For this week only, introductions will take the place of psychoeducation.) The facilitator may include an “ice breaker” activity such as a question or exercise to help group participants become comfortable with one another. The facilitator and group members determine and review group rules and expectations. After this introductory stage of the first group, the
facilitator will pass out notecards and markers. The facilitator will ask participants to consider what they wish to take away at the completion of the group process. Participants are asked to write these thoughts on the notecard (one thought per notecard). Once notecards are completed, group members give the notecards to the facilitator. (The notecards will be used during week eight). The facilitator answers questions and addresses group member’s concerns. The first session will close with a brief introduction to the psychoeducational topic for week two of the group process: mistaken beliefs and private logic (Griffith & Powers, 2007).

**Week two.** After the facilitator welcomes the group, the facilitator will engage group members in a discussion about mistaken beliefs and private logic (Griffith & Powers, 2007). As the discussion continues, the facilitator will explain how mistaken beliefs relate to social media and eating disorders. At this point in the session, the facilitator will distribute balloons and permanent markers. The facilitator will ask participants to blow up balloons and write any mistaken beliefs (Griffith & Powers, 2007) they believe the may have acquired or developed because of social media influence. Additionally, group members will be asked to brainstorm possible mistaken beliefs that may have developed as a result of a diagnosed eating disorder.

Participants will be asked to put one mistaken belief on a balloon (one statement per balloon). The facilitator will ask participants not to write a name on the balloon—only the mistaken belief. The balloons will be allowed to float around the floor while participants write additional mistaken beliefs on balloons. The facilitator will play instrumental (acoustic) music while participants are processing thoughts and feelings. Once participants have completed the exercise, the facilitator will ask group members to acknowledge the amount of balloons in the room.
At this time, participants will be asked to pick up random balloons, read mistaken beliefs out loud, and then drop the balloon again. The facilitator will ensure every participant has an opportunity to read a balloon. After all balloons have been read, the group will participate in a discussion about feelings related to the mistaken beliefs. The facilitator will draw attention to the similarities and the repetitive mistaken beliefs on the balloons. Group members will be given the opportunity to pop the balloons. (The facilitator should make certain all participants are comfortable with hearing the sound of a balloon popping. If any group member is uncomfortable, she will be allowed to leave the room during this part of exercise.) The significance of popping the balloon becomes a metaphor for releasing mistaken beliefs. When all balloons are popped, the facilitator will pause to allow for reflection during that moment (e.g., members will reflect on what it could mean to let go of mistaken beliefs, negative body image, and an eating disorder). The facilitator addresses questions and concerns and closes the session with a homework assignment. Group members will be asked to reflect on mistaken beliefs and to consider personal private logic and how a change in private logic could have an impact on the future. Group members will be asked to bring this written reflection to group during week three.

**Week three.** The facilitator will welcome participants and address questions, concerns, and announcements. The facilitator will ask participants to turn in the written reflection assigned during week two. The facilitator informs group members the homework will be returned for use during week seven. At this point in the session, group members will be asked about initial thoughts that come to mind when hearing the words “encouragement” and “courage.” After responses from the group, the facilitator will engage members in a discussion regarding Adler’s concept of encouragement (Griffith & Powers, 2007).
A brief overview of Brene Brown’s work will take place prior to viewing the TED Talk video *The Power of Vulnerability* (Brown, 2011). After viewing the video, participants and facilitator engage in an open discussion. When the discussion ends, the facilitator will close by addressing any questions the group members may have.

**Week four.** The facilitator will welcome participants and discuss questions or concerns. Once questions have been answered, the facilitator will engage group members in a discussion about externalizing the problem (White & Epston, 1990). The facilitator will explain how this process can separate group members from the eating disorder and social media. Next, the facilitator will bring out a white board and ask group members to form a circle around the white board. The facilitator will ask participants to brainstorm possible effects of an identified eating disorder or body image problem. After adequate time to brainstorm, the facilitator will ask group members to shout out possible effects. The facilitator will write all potential effects of the identified problem, and then will ask group members to discuss the feelings associated with the words on the white board.

Finally, the facilitator will pass out paper and pen to participants. The facilitator will instruct group members to begin writing a breakup letter to the problem. The facilitator will direct group members to write freely and ensure the participants the letters will be for personal viewing only. The facilitator will play instrumental (acoustic) music while participants are writing. If additional time is needed to complete the letter, group members may complete the letter at home. The facilitator will close by addressing any questions the group members may have.

**Week five.** After the welcome, questions, and announcements, the facilitator will engage the group members in a discussion regarding sparkling events (White & Epston, 1990). The
facilitator will ask group members to reflect on past experiences where participants were engaged in a personal struggle. Specifically, participants will be asked to consider a difficult event with a positive ending. Group members will engage in a shared discussion and the facilitator will validate the achievements shared during the session.

The facilitator will distribute paper and markers to group members and direct group members to draw an outline of their hands. Group members will be asked to consider the impact of social media on body image and the struggle with an eating disorder. The facilitator will ask participants to consider how social media may have triggered negative thoughts and direct group members to list these thoughts on the left-hand side of the paper. Participants will be asked to consider how a healthy lifestyle would feel if they changed current thoughts. Group members will write thoughts on the right-hand side of the paper. Once participants have completed the exercise, the facilitator will conclude the session by asking group members to discuss actions to overcome current negative feelings. After the group discussion, participants will be asked to bring a pillow and blanket to the following session.

**Week six.** The facilitator will welcome participants and allow time for questions and concerns. Once questions have been answered, the facilitator will engage group members in a discussion regarding DBT (Linehan, 1993). Participants will engage in a mindfulness activity: the body scan. The facilitator will direct group members to lay down with the pillow and blanket and begin to relax by taking deep breaths. The facilitator will begin the *Jon Kabat-Zinn: Body Scan* video (Kabat-Zinn, 2015). Prior to closing, participants and facilitator will address thoughts and feelings that may have surfaced during the body scan activity.

**Week seven.** After the facilitator welcomes the group, group members receive the written reflection from week three. The facilitator will engage members in a discussion about the
preferred story (Brown & Augusta-Scott, 2007). The facilitator will distribute journals to each group member and explain the process of writing a preferred story. The facilitator will ask participants to brainstorm and write chapter titles that may be included in the story. The facilitator will encourage participants to reference the written reflection from week three to separate from the past and develop chapter highlights. The facilitator will play instrumental (acoustic) music while participants are processing thoughts and feelings. At the end of the session, the facilitator will address questions and concerns and ask group members to bring the journals to the next group session.

**Week eight.** After the welcome, questions, comments, and concerns, the facilitator will ask participants to continue to write the preferred story. The facilitator will play instrumental (acoustic) music while participants write and process thoughts and feelings. Participants will be asked to stop writing and close the journals. The facilitator will review the notecard exercise from week one. After the facilitator reads the notecards, participants and the facilitator will engage in an open discussion reflecting on the last eight weeks. The facilitator will encourage group members to finish the preferred story and share it with someone. The last session will close with final thoughts, comments, and reflections. The facilitator will provide written literature and local resources to group members for continued support.

**Recommendations for Future Research**

As technology and social media advance, mental health professionals could benefit from additional research on the social media and eating disorders. Future research could include longitudinal studies that follow an adolescent cohort to adulthood. Specifically, researchers could address the level of connection to social media, eating disorder progression, and future implications regarding the correlation between the two. In addition, researchers could follow
younger children through adolescence to discover the impact of social media and peer influence prior to adolescence. Potential areas of research could include: the type of television shows children watched as they moved from childhood to adolescence, time spent with friends, involvement in community and peer-related activities, and the amount of time caretakers spent with the children as they age. Research could also include potential evidence-based training methods for school counselors and therapists regarding social media influences and body dysmorphia.

Future research could focus on pilot initiatives attempting to intervene between social media and the potential risk for eating disorders. Currently, Mclean, Wertheim, Masters, and Paxton (2017) are completing a study with such an initiative. Similarly, another recent publication from Verma and Avgoulas (2015) investigated how young women viewed different eating disorders and how exposure to social media may have had an impact on the way women viewed eating disorders. Recent research by Heres et. al. (2017), considered how narrative therapy, combined with an Adlerian approach, was beneficial for individual or group therapy when used to improve a client’s private logic, mistaken beliefs, and capacity for social interest.

**Conclusion**

When adolescents struggle with eating disorders, the therapist and the adolescent need to find a way to work together to diminish negative thoughts about the body ideal and body image to establish a foundation of healthy thoughts and behaviors (Sperry & Carlson, 1996). The suggested approach to treatment would include mindfulness, empowerment, and encouragement. The adolescent would be encouraged to focus on daily efforts instead of what they may or may not have accomplished in a certain time period (Seligman, 2004). This focus would help adolescents form a new relationship with food, social media, and peer groups. An Adlerian
therapist would emphasize an increased social interest (Ansbacher & Ansbacher, 1956).

Through an investigation and discussion of the adolescents perceived style of life and private logic, adolescents could begin to understand the etiology of an eating disorder and body dissatisfaction. The therapist could engage adolescents in an individual or group process. Through the use of narrative therapy, the therapist could guide the adolescent toward a greater understanding of self and co-author a new, preferred client story.
References


Appendix

Adolescent Eating Disorder Group

Week One

Introductions/Overview of course

A. Introductions

B. Expectations of group and groups members

C. Notecard exercise

D. Open discussion for questions and/or concerns

E. Session Closure

Week Two

Mistaken Beliefs/Private Logic

A. Definition of mistaken beliefs and private logic

B. Mistaken beliefs and eating disorders

C. Mistaken beliefs and Social Media

D. Group exercise

E. Open discussion for questions and concerns

F. Session Closure

Week Three

Encouragement/Courage to be Imperfect

A. Definition of encouragement and courage

B. Brene' Brown

C. Watch video *The Power of Vulnerability* by Brene' Brown

D. Open discussion about video
E. The courage to be imperfect vs the eating disorder

**Week Four**

Externalizing the Problem

A. Definition of externalizing the problem
B. Identifying the problem
C. Effects of the problem over you
D. Breakup letter

**Week Five**

Sparkling Events

A. Definition of sparkling events
B. Overcoming problems of the past (brainstorming personal achievements)
C. Discussion of sparkling events in relation to social media and eating disorders

**Week Six**

Mindfulness

A. Definition of dialectical behavior therapy (DBT)
B. Body scan exercise
C. Open discussion on thoughts and feelings

**Week Seven**

Preferred Story

A. Definition of preferred story
B. Separating from the past
C. Chapter titles

Week Eight

Preferred Story (con’t)

A. Continue with preferred story

B. Revisit notecard exercise from week one

C. Group closure