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Storytelling as a Therapeutic Tool for Family Support in Bulimia Nervosa

*José Vicente Martínez Quiñones, Mar Martínez Gamarra
and Ignacio Jáuregui Lobera*

Abstract

Telling stories (storytelling) is, above and beyond, a form of communication. It is a natural, universal, and well-known way of interaction among human beings. Storytelling, orally as well as in writing, is the sharing of personal narratives, a sort of story-sharing. With regard to chronic disease self-management, storytelling has been reported to be an exciting approach to patients and families. In this regard, families are considered very important in the management and treatment of eating disorders. Living with an eating disorder is an experience which deserves to be expressed in order to improve emotional support always necessary for patients' families. Bearing in mind that eating disorders can be chronic illnesses that lead to challenging and troublesome experiences for patients and their families, this chapter aims to think over the everyday interactions that typify family life in the context of eating disorders and specifically in the case of bulimia nervosa. We propose this text as a reflection based on different experiences when working with bulimic patients.

Keywords: storytelling, eating disorders, bulimia nervosa, family support, narratives

1. Introduction: what is storytelling?

Storytelling (ST) is a well-known tradition in human culture since people tend to tell stories for many reasons such as entertaining, transfer of knowledge between generations, maintenance of cultural heritage, warning others of dangers, etc. Telling stories with serious (non-entertainment) objectives has emerged as a new way for potential applications in different contexts (e.g., medicine or psychology) [1].

Above and beyond ST is a communication tool among human beings with a core aspect which is the emotions. "Serious" ST is an earnest narrative, a way to tell stories outside the context of entertainment. ST has different components such as narrative, perspective, interactivity, and medium. *Narrative* is the actual content of the story, which includes times-contexts, causes-effects, sequence, etc. *Perspective* refers to the fact that in each story the author conveys a subjective point of view of a certain aspect of the story. Perspective includes facets such as cognition, emotions, encoding-decoding, meaning, memory, etc. *Interactivity* is essential in ST, including

story features such as engagement, modification/decision of narrative flow, etc. Finally, *medium* includes mediation, channels, forms, etc. When ST is defined as a narrative, two components must be considered: the narrative content (story) and the narrative form (discourse). Stories and discourses build a fundamental way for humans to make sense of the world (**Table 1**) [2].

Serious ST refers to a non-entertainment context, where stories are part of the real world. It aims to create mental models about different areas in which narrative elements such as engagement, conflict, characters, emotionality, meaning, cause-effect relations, and time and space constraints are adapted to convey experiences [1]. A narrative is a vehicle to trigger emotional and cognitive responses to achieve certain serious goals within their context of solicitation. In addition, interaction becomes a matter for decision processes, knowledge creation, communication of nonquantifiable facts, and altering narrative flow to achieve serious contextual goals. Context, course, content, and channel are the four essential components of serious ST. The context is basically the application of circumstances (e.g., medical or psychological problems); the course would be how content evolves in a cause-effect relationship as part of the application context; the content is the actual ideas contained in the narrative; and the channel is the kind of way to communicate stories [1, 2].

With respect to the context, the applications of serious ST in well-being, health, medicine, and psychology are good examples of the multiple possibilities in this field of study [3, 4]. From a scientific point of view, and following Dahlstrom et al., we prefer using the concept of “scientific storytelling” when we apply it in medical investigation [5].

The objectives of our reflection were to propose ST as a tool to offer family support in eating disorders (ED) and to describe the development of the story-based interventions targeted to families (developing communication strategies). It must be noted that ST is a way to communicate (mainly emotional narratives) but not a specific therapy for ED.

With respect to the method, due to the fact that this chapter is based on a future review, which we are developing (“storytelling and health education”), the main data of our reflection are taken from a search using PubMed/MEDLINE and PsycInfo, considering those articles mainly focused on ED and specifically on bulimia nervosa.

Elements	Meaning	Instruments
Narrative	Content (story) Form (discourse)	Time-context Cause-effect Sequence
Perspective	Subjective point of view	Cognition Emotion Encoding-decoding Meaning Memory
Interactivity	Story features	Engagement Modification Narrative flow
Medium	Means of communication	Mediation Channels Forms

Table 1.
Basic components of storytelling.

2. Results

2.1 Storytelling in medicine and psychology

The effectiveness of ST as a communication tool in healthcare has been supported by evidence from several disciplines [6].

Within the healthcare context, ST might be seen as a way of assistance in learning about and managing one's disease or a relative's disease. ST aimed to disease management is based on the fact that each person has his or her own unique experiences living with and managing a disease; the same applies for relatives. Thus, patients and patient relatives' stories are a relevant information source to both patients and families [7].

In this way, storytellers are patients and patients' relatives who suffer together a disease or disorder. By identifying with the storyteller, participants can become invested in the content and be positively influenced by the self-management actions described. Telling stories, emotional stories, is a very good tool to break down cognitive resistance to messages promoting lifestyle and behavioral changes [7] or, many times, to get involved in adequate care and support. Through ST, patients increase their receptivity to the health information contained in the stories as it occurs among patients' families.

In sum, ST is a way to motivate both patients and families [6]. In this regard, ST, as a mechanism for reduction in change resistance, is related to health outcomes [7]; it makes patients and families more inclined to follow strategies that have worked for others (and perhaps they have previously avoided) [8]; it reports mutual benefit (discovery and exploration of new information, practical management strategies and skills, opportunities for adoption of resolutions, etc.) when patients/families exchange their health-related stories [9–11].

When ST is developed in a group format, several authors have reported different benefits [12–15]:

- ST might establish a network of trust and equality among participants, and it would be a way of cohesion among participants.
- ST tends to reduce stigma associated with diseases, and it facilitates the development of relationships among the participants.
- ST can naturally facilitate peer support and enable a support network to form.
- The peer support obtained by means of ST might encourage participants to examine their emotions, problem-solving skills, and goal setting and exchange social support, all of which are core self-management components within health-related contexts.

In summary, ST focuses on the patient's perception of their unique needs and their ability to self-manage their disease and similarly occurs when ST is applied to patients' families. Consequently, ST facilitates both patients and families to develop strategies to manage their illness and suffering, respectively [16].

2.2 Storytelling in chronic diseases

Chronic diseases usually require regular contact between patients/families and therapists. In this particular way, ST could be a good approach for both patient self-management and family management. For this proposal, core principles of

ST, when applied to health contexts, have been reported to be social cognitive and ecological theories of health behavior, caring and healing, and narrative-autobiographical approaches [17–20]. There are two main objectives of ST in health interventions: (a) to get patients/families to reflect the illness experience and (b) to create meaning from it [20].

As Gucciardi et al. have reviewed, health conditions such as diabetes mellitus, cancer, multiple sclerosis, or psychiatric disorders are frequent diseases in which ST has been applied [20]. Sessions of ST are based on informal-spontaneous sharing of stories by means of a nondirective facilitation approach. Sessions do not consist of didactic delivery of information even though “facilitators” (doctor, nurse, dietitian, etc.) can respond to the shared stories and they can also provide information if required. In this context facilitators play a role of equality but not of experts. Finally, ST must have some elemental rules such as trust, respect, empathy, and no judgment [12, 20, 21]. Sometimes it is possible to use “peer facilitators” (e.g., patients’ relatives) previously trained as health promoters and, of course, in ST [12].

Sessions of ST applied to chronic diseases tend to be given over 5–15 weeks, with each session lasting 1–2 hours. The environment usually is an open atmosphere, thus giving everyone the opportunity to speak about their experiences. It is convenient to select topics in advance in order that participants prepare the session with the story (or stories) they want to share in the group (e.g., diagnosis experience, course of the disease, family stress linked to the therapeutic aspects, etc.) [22]. The way to share stories is diverse: verbally, by means of action-oriented activities (e.g., cooking, exercising, etc.), using pictures, writing, through songs, poems, and readings. ST is not a mere colloquium; it is a participant-centered technique of communication where patients and families are encouraged to self-reflect on their personal experiences.

In the context of chronic diseases, ST is not a way of simple catharsis. Telling stories about illness experiences seems to be therapeutic due to its potential to facilitate learning and coping with the disease. As it was noted by Gucciardi et al., ST is a process of unearthing meaning in the lived experience of illness [20]. Telling stories triggers the reflection and understanding of oneself and the disease [23]. The process of ST starts as a single story (my story), and then stories are elaborated by group participants thus becoming a shared experience [21]. Different ages, groups, ethnicities, socioeconomic status, or gender are potential participants of ST applied to health problems. With respect to ideal number of sessions, basing on participants’ preferences and bearing in mind the complexity of the self-management of the disease are better. As it was abovementioned, the use of verbal and written formats is the main strategy along with pictures or photographs [20].

The role of narratives has grown in relevance since the 1980s due to the importance of illness experiences. It must be noted that narratives reflect the nature of the chronic disease experiences but also can be a part of it [24].

2.3 Storytelling and eating disorders: families

Traditionally, families are considered to play a key role in the management and treatment of ED. Families do not suffer from an ED, but they live with an ED. In this regard families’ stories are a way to create experiences, experiences linked to the emotions which usually accompany a life with an ED.

In the field of ED, families have been associated with relationship alteration within the family, problems between partners, great stress experience, problems to cope successfully, uncertainty regarding recovery progress, parental blaming, etc. [25–30]. ED, as it occurs generally in chronic diseases, might be described as a form of biographical disruption which breaks individual or family-anticipated

life paths. As a consequence, narratives lose coherence and meaning and identity becomes lost. The result is a new narrative incoherence which will imply a narrative reconstruction. Stories, ST, will provide new coherences thus giving meaning to ED [31, 32].

Frank [33] considered three narrative types with respect to stories of illness: restitution, chaos, and quest. The first seems to be dominant, and, in sum, it consists of sentences such as “yesterday I was healthy, today I am sick, tomorrow I will be healthy again.” On the contrary, chaos narrative is the opposite of restitution, something like “life never will go better again.” In this case there is not a narrative coherence to explain the illness. Finally, the quest narrative implies that patients see illness as an opportunity to believe that something is to be gained from the illness experience. Telling stories such as restitution, chaos, or quest narratives has not the same results. Each one shapes experiences. Thus, restitution narratives are usually associated with the fact to pursue, be hopeful, and expect recovery. If the narrative of storytellers shapes their own experiences, the same occurs with regard to the listeners, who, in turn, would also modify their illness experiences [33, 34].

It has been established that ED affect all facets of life and they are a challenging experience for the whole family [34]. It is frequent that parental understandings of illness can remain couched in restitution. Nevertheless, when family members construct ED differently to each other, the consequence is the conflicting narratives and, finally, frustration, anger, and altered communication [34]. Considering the three narratives as suggested by Frank [33], it is possible to observe a process during the therapeutic work in ED (**Figure 1**).

ED are usually chronic disorders, thus being both a challenge and a source of family problems. Within the family system, a process of meaning-making will emerge which is absolutely necessary to cope with the illness. This process is guided by culturally dominant illness narratives as stated by Frank [33].

2.4 Storytelling and eating disorders: patients

When patients with ED are the storytellers, it is possible to distinguish two very different narratives: the discourse of anorectic and bulimic patients [35, 36].

The discourse of patients with anorexia nervosa is built upon three pillars: intensification, circularity, and polarization. This discourse presents a defined reality characterized by excess, conflict, and closing [35].

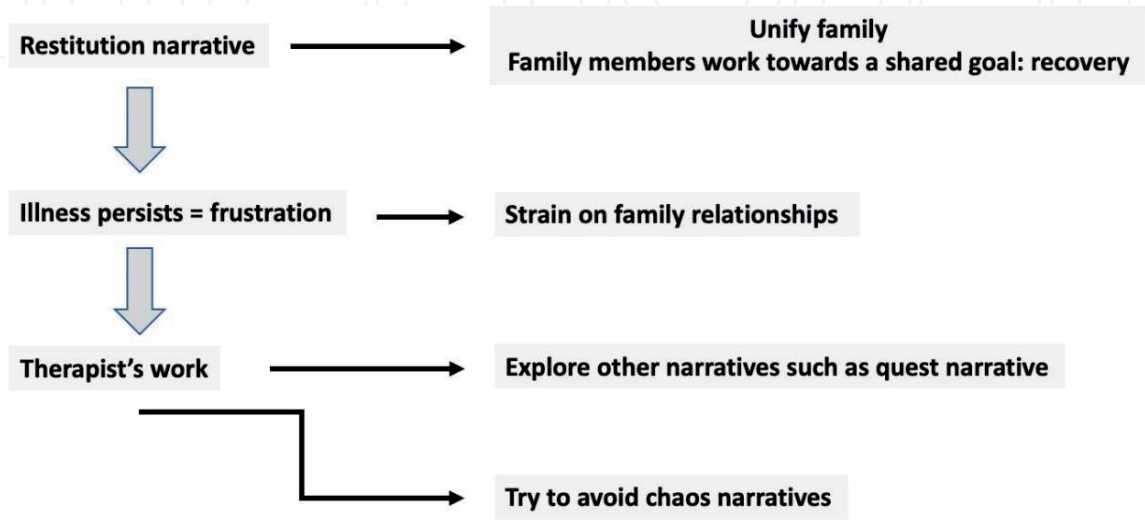


Figure 1.
Therapist working with ED. Adapted from Papathomas et al. [34].

Intensification leads to derealization, thus showing a distorted world with regard to its dimensions. On the one hand, it is a vehicle to express very intense feelings; on the other hand, intensification does not end up with this expressive function since it serves as a strategy to legitimate specific behaviors [35].

The amplified image of reality triggers the alarm; it expresses an obsessive fear to gain weight. Thus, body image is perceived to the limit of bearable, and this seems to justify the obsessive desire to lose weight. Maybe the discourse shows the object: the distorted image acts generating fear, thus becoming a relevant factor which maintains the disorder. The dichotomic vision of reality reinforces anorectic behaviors since that vision implies a fight between contrary parts. The result is an experience of a fragmentary world and a split-off vision with respect to the own conscience. Antithesis, paradoxes, and generally the dialectical approach keep alive and reinforce the awareness of both external and internal confrontation, and, as we have seen, once the conscience is divided between opposing parts, it is always defeated in this war of no one [35, 36].

Circularity, showed linguistically by a high degree of recurrence, creates a net of words which envelops and imprisons. As the water of a fountain reflects the image of Narcissus, anorectic discourse throws an image which locks one inside; that discourse shows a conscience turned on itself, tightly centered and closed on the conflict. From this point of view, anorectic discourse is both an expression and an instrument of the disease. At the same time, that discourse has the keys which might neutralize the disease effects. If the discourse catches and it makes the person sick, it is possible to build another different discourse to create and legitimate a healthy behavior.

Considering positive and negative elements of anorectic discourses, it would be possible to include the analysis of discourse within the whole treatment program. By means of the analysis of recordings and texts, it is possible to think over with a critical point of view about the patients' thinking schemes. Then it would be possible to build an alternative discourse, a new healthy discourse [35].

In the case of bulimia nervosa, as a feature that defines the discourse, its openness from the thematic point of view and also some peculiarities in what refers to the global construction of the discourse should be noted. From the thematic point of view, stories usually show a universe open to others, with a central theme, which is dependent on affection and recognition of others [36].

Following the studies of Márquez [35, 36], considering bulimia nervosa, perhaps the most outstanding feature, along with the fragmentary character of the discourse, is the polyphony: voices of the same person or of the others, real or imagined, that give life to the story, make it rich and complex, and, at all events, show a consciousness inhabited by others, confused with them.

In the syntactic plane, the global organization of the discourse is defined by its scattered character: broken syntax with unfinished structures, suspended utterances, and sudden alterations in rhythm show a specific type of thought which is built on impulses.

Verbalization of experiences, reflection, and reconstruction of memories are emerging to consciousness in a choppy way, in various attempts that are not usually alternatives to saying the same thing (or different ways of approaching a fact), since the first tend to be unsuccessful. Stories are characterized by impulsivity, ruptures, advances, and setbacks, which, in short, express precipitation, lack of a necessary prior time for reflection and planning, lack of containment, and difficulties in adjusting to limits.

Intensification presents facts and sensations as endowed with an extreme force; as a result, reality is constructed with such intensity that it is uncontainable within its natural channels. Thus considered, this resource serves as legitimization of the

illness behaviors. Vocalic lengthening and sudden changes in the language rhythm, as well as precipitation and slowing down, also show the presence of emotions that overflow the consciousness, sensations, and affects that are difficult to conduct and finally become not contained.

In short, a broken speech seems to reflect the lack of a coherent internal organizing center, a broken voice, a word that has its justification and its center abroad, as an echo [36].

From a dialogical view of change, it is possible to consider change and resistance to change. Resistance to change derives from the slavery of repeating, which traps the dialogical self. The tension between change (liberty of reborn) and resistance to change (self-determination to repetition) can be also represented as voices discussing and contrasting in the context of a personal arena, in the dynamic of a dialog between parts [37].

2.5 Work with families in eating disorders

It is usual to work with families when an ED patient begins his/her process of treatment. There are two facts which we can observe at this point. Firstly, families tend to express that they never imagined a son or daughter with an ED. Second, it is frequent that families talk about their “fault.” Novelty and fault build a recurrent question: Why?

It has been said that healthy relationships are like the tides: they ebb and flow, especially when it comes to verbal interaction. Ebbing and flowing give as a result a balance. But when a family member suffers from an ED, this balance is very hard to maintain. When this occurs, the patient becomes quite self-centered, self-absorbed. Now, relationships as well as dialogs need to be rebalanced. Once an ED affects a family member, many times siblings are victims of that ED since parents focus much more of their time, thoughts, and energy on that affected member. Verbal interactions and relationships are strongly modified. From the point of view of siblings, the patient gets all the love, all the attention, while other members get ignored and overlooked. In order to attract parents’ attention, siblings may start some unhealthy behaviors such as rebelling, acting out, etc. [38].

ED often is an enemy of healthy relationships. As an ED develops and progresses, it often takes the place of wholesome relationships that may have once existed in one’s life. Typically, as the ED roots within a person, relationships with family members, friends, partners, etc. become strained and gradually altered [39].

Altered relationships within the family tend to create a different discourse. The coherent healthy discourse becomes a broken discourse stained by feelings of doubt, guiltiness, and many times lack of hope. This way a new story emerges. Patients, siblings, parents, partners, etc. have their new particular stories to tell or, sometimes, shut up. During the therapeutic process of ED, there are very different elements that parents refer to as having a great impact on their lives. Examples of these elements would be family unification or disintegration, inability to cope with the disease, inconsiderate comments from significant others, social isolation, and financial impacts, among others. The chronicity of ED causes stress for the family as a unit, by affecting the family’s coping mechanisms and the family’s relationships with significant others leading to isolation of the family unit [28].

Isolated parents give few insights into the ED experience across the whole family unit. Illness experiences may be analyzed through thematic analyses. Although these content-driven approaches can be useful, they offer scarce for the social construction of the ED experience. Specifically, how personal interpretations of illness are shaped through social and cultural narrative auspices is rarely addressed. It is in this regard how ST would be an appropriate tool to understanding illness. The role of narratives,

the role of telling stories, would lead to the deepest personal illness experiences. Narrative therapy for ED is well known since the 1980s. By means of telling stories, therapists work with patients, who create a sort of “anti-anorexia” and “anti-bulimia” stories. These stories aim to depict a separation between the person and the disorder, thus setting up space for patients (and families) to re-envision their relationship with their ED. Patients will create a new personal story “without the ED.”

2.6 Bulimia nervosa: patients and families. Dialogical analysis with ST

Along with bulimia nervosa, it has been reported that 61.5% of youth with this ED could be considered to have one or more comorbid disorders (especially mood disorders, anxiety disorders, and personality disorders) [40]. In this particular way, ST might be applied not only in the case of bulimia nervosa but also when comorbidities are present. Thus, using narrative therapy in a group of women with long-course ED with comorbid depression, a reduction in both ED and levels of depression was obtained. It seems necessary to work with different facets: (a) externalize the ED, thus creating distance between herself (patient) and the disorder; (b) explore the person's ED, in which values belong to the patient and which belong to the ED; and (c) develop an alternative story to support the client's sense of self (not just with respect to eating but in other areas of her life); it is not the same “to be” a bulimic patient than “to suffer from bulimia nervosa” [41].

ST is a way of communication, a way to change the discourse, thus contributing to change our mind. Many patients usually say “I can't start again” and “it is impossible to change.” But if the patient does not change, the result is the permanence. The same applies to families. Between change and permanence emerges the conflict, and the discourses serve the conflict becoming broken, incoherent. Stories may be based on change and on no change. The consequent discourse is a speech aimed to express the deep desire of change or, on the contrary, the conviction to permanence, the change being impossible. As Marquez stated [35, 36], change vs. non-change is something like an inner dialog between voices, but not only “inner” since external components appear (family, partner, friends, etc.). As stated by Salvini et al. [37], the dialog between voices implies that when one party speaks, the other party is required to be silent. This way, it is common that a dominant discourse emerges (interactional dominance), the dialog being asymmetrical. Therapists must consider this phenomenon because the more symmetrical the dialog is, the more opportunity it provides for mutual influence; the more asymmetrical it is, the more it constrains the exchange of views and experiences. When symptoms are the core part of the discourse and this discourse becomes dominant, patients and families are imprisoned. Following the analysis of Márquez [36], in bulimia nervosa stories are characterized by impulsivity, ruptures, advances, and setbacks, which, in short, express precipitation, lack of a necessary prior time for reflection and planning, lack of containment, and difficulties in adjusting to limits. This style usually leads to a chaos narrative [33].

Based on the study of Hermans et al. [42], Salvini et al. [37] considered the trend toward discursive change during the therapeutic process according to the following four dimensions: (a) interactional dominance, (b) topic dominance, (c) amount of talk, and (d) strategic movements. In a process of scientific ST, it is relevant to analyze linguistic variations probably linked to a transition from a dysfunctional narrative to a new more coherent one. Among a group of bulimic patients (here bulimic storytellers), one of them could be dominant, and the dialog starts being very asymmetrical. With respect to the topics, diets, body image, emotional instability, binge episodes, purging, and other altered behaviors (e.g., self-injuries) are usually highlighted by group members. At the beginning the amount of talk and strategic

movements might be summarized as a scarce of true dialog with different attempts to impose one over others. Each member seems to search for a top position in the group, thus polarizing and dominating the other voices [37]. As the sessions go on, a more reciprocal interaction is favored. The topics remain but they are less strong than before. In order to understand these changes, it is necessary to bring here the concept of metaposition, something like a “third voice.” This third voice has a reflexive function. Some auxiliary verbs (*I have to be treated, I want to get better*, etc.) are contrasted by more verbs which imply personal conditions (*I feel happy, I do not like*, etc.). With the progression of the ST process, the preferred tense is the past, thus distinguishing between a previous condition and the current state (*when I binged, once I felt frustrated and I used laxatives*, etc.). Step by step a passage from a condition of dysfunctional self-narratives to more organized ones is observed.

As reported by Marquez [36], the discourse may have a relevant role in maintaining the problem, but it is possible to pass from a broken discourse to another healthier one. The discourse reveals psychological profiles as well as interaction styles. In the field of ED, and particularly in bulimia nervosa, working with ST should aim to introduce a “language of change” for both patients and families.

2.7 Topics to listen from bulimic storytellers

Characteristics of bulimia nervosa involve the sufferer bingeing on large amounts of food, during which patients experience feelings of extreme loss of control. Bingeing leaves the patients feeling guilty, disgusted with themselves, and afraid of weight gain. Patients try to compensate for this by vomiting, by exercising, by fasting, by abusing laxatives, or often by some combination of these behaviors. The life of bulimic patients is usually chaotic: dieting, bingeing, purging, fear to weight gain, feeling of being fat, etc. As result, patients have a negative view of themselves which usually leads to avoiding social interactions. Low mood and poor quality of life complete this framework.

In a ST group, some topics will emerge soon:

1. What is bulimia nervosa?
2. Effects of bulimia nervosa in my life (physical, psychological, and social facets)
3. Dieting
4. Is it possible to change my way of thinking?
5. What are thinking errors?
6. Coping with problems and emotions (anxiety, depression, fear, etc.)
7. Body dissatisfaction
8. Assertiveness
9. How is my future?
10. Can I help myself?
11. Bulimia nervosa has many disadvantages for me but has it any advantages?

12. What is a vicious cycle (diet-binge-diet; purge-binge-purge, etc.)?
13. What induces me to binge?
14. What triggers diet-binge-purge?
15. Can I remember what is normal eating?
16. Is this a healthy life?
17. Am I aware of the links among feelings, thoughts, mood, behavior, relationships, etc.?

In ST “emotional meanings” are essential. Patients with ED assign different meanings to their disorder. Those meanings are reflected in their narratives, their illness experiences told in their particular stories. Patients with bulimia nervosa usually have maladaptive thoughts and emotions related to eating habits and body weight. They also have low self-esteem, and they seem to be sure that a well-designed body would be a remedy for their problems of personal insecurity. In this regard, their behaviors aim an idealized body through diets, purging rituals, and often strenuous exercise. The chaos is based on the fact that the desire to lose weight is associated with a personal disorganization. As a result, regulation and control over eating become an attempt to organize and stabilize the chaotic mental state [43]. ST is a good instrument to communicate emotional experiences and a way to access patient’s difficulties and internal conflicts. In fact, narratives can be seen as expressions of the self and the living experience for the individual who narrates. The link between individuals and their “bulimic (or anorectic) voice” could explain their ambivalence to change [44–46].

Apart from the abovementioned topics related to the patient’s current problems and family-related features, there are different meanings with respect to the onset of the disorder. Low self-esteem, clusters of stressful events, new experiences/difficulties emerged with the disorder, feelings experienced after the onset of the disorder, etc. are usually core parts of the patients’ narratives [43].

As other therapeutical approaches, ST aims to produce changes. Patients and families could expect changes to happen such as more dialog, closeness and affection between family members, fewer conflicts between siblings, greater family participation in treatment, more family togetherness, less critical comments, etc. Considering families, the desire to change family dynamics seems to facilitate a healthier environment and consequently a clear improvement in the therapeutic progress. Generally, family emerges as the main source of patients’ social support.

3. Discussion and conclusions

ST is a communication tool among human beings with a core aspect which is the emotions. Narratives are a vehicle to trigger emotional and cognitive responses to achieve certain serious goals within their context of solicitation. With respect to the context, the applications of scientific ST in well-being, health, medicine, and psychology are good examples of the multiple possibilities in this field of study. Considering health contexts, storytellers are patients and patients’ relatives who suffer together a disease or disorder. In this particular way, ST is a manner to motivate both patients and families, ST being a mechanism for reduction in change resistance, which is usually related to health outcomes. In the context of chronic

diseases, ST is not a way of simple catharsis. Telling stories about illness experiences seems to be therapeutic due to its potential to facilitate learning and coping with the disease. ED are usually chronic disorders, thus being both a challenge and a source of family problems. Within the family system, a process of meaning-making will emerge which is absolutely necessary to cope with the illness. This process is guided by culturally dominant illness narratives as stated by Frank, and it was abovementioned [33]. As reported by Marquez [36], the discourse may have a relevant role in maintaining the problem, but it is possible to pass from a broken discourse to another healthier one. The discourse reveals psychological profiles as well as interaction styles. In the field of ED, and particularly in bulimia nervosa, working with ST should aim to introduce a “language of change” for both patients and families. As it was abovementioned, impulsivity, ruptures, advances, and setbacks, which, in short, express precipitation, lack of a necessary prior time for reflection and planning, lack of containment, and difficulties in adjusting to limits, are a cluster which define the interaction between family members and a patient diagnosed with BN. This style usually leads to a chaos in both narrative and relationships (in the case of anorexia nervosa, the circularity—manifested linguistically in the high degree of recurrence—weaves with words a network that envelops and imprisons; the discourse projects an image that encloses the subject within himself; the discourse shows an awareness turned inward, hermetically centered and closed on the conflict, thus affecting a clear dialog with others) [35, 36]. In sum, ST aims to produce changes, in both discourse and relationships. Patients and families could expect changes to happen such as more dialog, closeness and affection between family members, fewer conflicts between siblings, greater family participation in treatment, more family togetherness, less critical comments, etc. Considering families, the desire to change family dynamics seems to facilitate a healthier environment and consequently a clear improvement in the therapeutic progress. Generally, family emerges as the main source of patients’ social support.

ST is above and beyond a useful form of communication. ST is not a specific therapy, and its great advantage is to improve the existing therapies by means of a better communication between therapists and patients as well as between family members and patients. With respect to ED, a patient (that is to say a “storyteller”) could summarize, in a delightful poem, the process of changing of someone who starts suffering from anorexia or bulimia nervosa (and still is sure to control it) until they reach a point of no return. The capital letter of each verse wants to reflect the inner highness of the affected person.

Due to the original language in which the poem has been written down, we have decided to maintain the Spanish version as well as to translate the poem into English.

I WISHED TO BE...

*And I wanted to be waning moon just not to be sun.
And I imagined myself to be fine and delicate rainfall.
And I was a beautiful Caladium with a slender stem.
And I dreamt of being a horse chestnut tree with an upright and leafy trunk.
And I tried to be Artemisa or Apollo.
But I became a goldfinch that could not sing and my colors faded without my knowing why.
And ceased being an Alpha Canis Majoris when my shine dimmed.
When the failed transformation occurred.
All the figures that my mind reflected were slimline.
Until I did not want to be, until I did not think.
Because I was just looking for perfection.*

Y QUISE SER...

Y quise ser luna menguante para no ser sol.

*Y me imaginé ser lluvia fina y delicada.
Y fui hermosa Caladium de tallo esbelto.
Y soñé ser un castaño de Indias con el tronco erguido y abundante hojas.
Y fingí ser Artemisa o Apolo.
Pero me convertí en un jilguero que no podía cantar y perdí mis colores sin saber la razón.
Y dejé de ser una Alpha Canis Majoris cuando perdí mi brillo.
Cuando sucedió la transformación fallida.
Todas las figuras que mi mente reflejaba eran finas.
Hasta que no quise ser, hasta que no pensé.
Porque solo buscaba la perfección.*

Author details

José Vicente Martínez Quiñones^{1*}, Mar Martínez Gamarra²
and Ignacio Jáuregui Lobera³


1 Department of Neurosurgery, Mutua de Accidentes de Zaragoza, Zaragoza, Spain

2 Storytelling Spanish Association (ASEST), Spain

3 Department of Molecular Biology and Biochemical Engineering, University of Pablo de Olavide of Seville, Seville, Spain

*Address all correspondence to: jvmartinez@maz.es

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