INTRODUCTION OF RESEARCH ISSUE

The purpose of my thesis study is to examine the participants’ experiences of short-term art-based support groups for adults living with eating disorders. In the following paragraphs, I will provide an introduction to the general subject area of eating disorders and discuss my rationale for selecting art-based support groups as my research topic.

According to the Diagnostic and Statistical Manual of Mental Disorders (IV-TR), eating disorders are classified into three categories – anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (American Psychological Association [APA], 2000, p.583-595). Regardless of categorization, eating disorders are serious, and often persistent, mental illnesses that can severely impact both the mind and the body. Continual preoccupations with food, body weight and shape can lead to profound and debilitating psychological disturbances, while prolonged engagement in disordered eating behaviours, such as self-starvation, purging and overeating, can cause irreversible damage to organ systems, long term health problems and increased mortality (Herzog & Eddy, 2007, p.2-26). In fact, the mortality rate of eating disorders has been reported at 18-20% – highest among all other mental illnesses (Cavanaugh & Lemberg, 1999, p.8). Despite the severity of the illness and its steady rise in incidence (Academy for Eating Disorders, 2009; National Eating Disorders Association [NEDA], 2009; Public Health Agency of Canada, 2002), there appears to be a chronic lack of funding for government-insured eating disorders treatment across Ontario (Kelly, 2008, para. 12-18; National Eating Disorder Information Centre [NEDIC], 2006). In Toronto, it is reported that the wait time for admission into a hospital adult treatment program can be as long as six months to a year (Ontario Community Outreach Program for Eating Disorders, 2007). Though many private counselling and treatment services for eating disorders are widely available (NEDIC, 2008), these options may not be viable for many people because of financial restraints.

Compounding the challenges of accessing treatment is the sufferers’ ambivalent attitude towards change and recovery (Wilson, Grilo, & Vitousek, 2007, p.199). Longitudinal studies indicate that relapse rates of eating disorders range from 33-63% (Cockell, Geller, & Zaitsoff, 2004, p.527); many practitioners
seem to share the impression that the prognosis for eating disorders is generally poor, and clients with this illness – especially anorexia – are particularly resistant to therapy or treatment of any kind (Cockell, Geller, & Zaitsoff, 2004, p.527; Rehavia-Hanauer, 2003, p.138; Kaplan & Noble, 2007, p.144). Few people whose lives have been touched by eating disorders – not only the sufferers but also their families, friends, and healthcare providers – would disagree that recovery is a process that often involves a slow, protracted course, with recurrent oscillations between progress and regression (Kerr, 1995; McFarlane, 2000; Cockell, Geller, & Zaitsoff, 2004, p.528). “Without treatment,” writes Makin (2000), an art therapist who has had extensive clinical experiences with anorexia and bulimia, “[eating disorders] can continue for decades, significantly impairing all aspects of life from work and health to relationships with others, if they do not kill the sufferer first." (p.24)

Although the lives of many sufferers had been greatly impaired or even lost due to the lack of available treatment or the sufferers’ own ambivalence towards change, their loved ones refused to lose hope. Over the past 15 years, these concerned family members and friends – many of whom were mothers who have lost their daughters to this devastating illness – had initiated and established a number of non-clinical, community-based support centres across Ontario to address the gaps in treatment services through providing free, accessible support to those suffering from eating disorders (Danielle’s Place, 2005; Eating Disorders of York Region, 2009; Hope’s Garden, 2008; Hopewell Eating Disorder Support Centre, 2008; Sheena’s Place, 2009). The services that these support centres provide primarily consist of professionally guided short-term groups with the aim of facilitating mutual support, and prospective clients can access these groups through self-referral (Danielle’s Place, 2005; Eating Disorders of York Region, 2009; Hope’s Garden, 2008; Hopewell Eating Disorder Support Centre, 2008; Sheena’s Place, 2009). These support centres differ from other treatment programs or services in that, although the vast majority of their group facilitators are professional service providers, they do not provide treatment, counselling, or therapy; in fact, these agencies simply do not have the legal licenses to perform these functions (Danielle’s Place, 2005; Eating Disorders of York Region, 2009; Hope’s Garden, 2008; Hopewell Eating Disorder Support Centre,
This lack of license may limit the extent of the service that a therapist can provide to his/her group. However, the non-treatment, community-based setting may create a less threatening environment for those who feel ambivalent about treatment and recovery to begin receiving support, building relationships, and engaging in a process of self-discovery and change (Kerr, 1995, p.3).

Art-making is often incorporated into these agencies’ programming in the form of theme-based support groups, workshops or open studio, facilitated by art therapists or professional service providers with fine arts training (Danielle’s Place, 2005; Hope’s Garden, 2008; Sheena’s Place, 2009). As an art therapy student who has spent seven years of her life battling anorexia, I hope to provide the best services possible to those suffering from eating disorders in my future work as an art therapist. Knowing that eating disorder support centres can potentially address the two major challenges that often hinder recovery – namely, the inaccessibility of treatment and the sufferer’s ambivalence – I became increasingly interested in knowing how art-making in a support group setting can be helpful for those living with eating disorders. I believe that these groups can be one way of making the therapeutic benefits of art-making accessible to eating disorder sufferers in different stages of recovery. This personal opinion about support groups is shaped by my past experiences with an eating disorder support centre. When I was told that I needed to wait up to six months for a consultation and then another six to eight months before a bed was available in a hospital treatment program, this agency opened its doors to me, and I felt less alone and more hopeful about recovery. Time and again when I left treatment prematurely and returned to this agency for support, the facilitators never judged or questioned my decision but simply welcomed me into their groups, where I was introduced to the process of allowing previously unacknowledged thoughts and life stories to unfold in art-making, journaling, and poetry-writing. When I finally committed to ridding my life of anorexia, the art-based support group was a way through which I could take small steps to appreciate life beyond the eating disorder; in addition, it was a practical means through which I could rebuild a sense of structure that was suddenly lost when the intensive inpatient treatment came to an end. Over the past year, I have heard
similar stories through my volunteer work and practicum placements in different eating disorder support centres. When I think about these personal accounts in relation to the theories and techniques I have learned through art therapy training, I realize that my own experience and a few casual conversations cannot provide enough information for me to draw conclusions about whether art-based support groups are helpful to those living with eating disorders. In order to gain a better understanding of this issue, I need to hear what the participants have to say about their experiences of these groups and critically analyze the information gathered.

It is my hope that the research findings will contribute to the fields of art therapy and eating disorders by identifying what participants find helpful or unhelpful about art-based support groups, especially regarding their recovery process. The results of this study may provide some focus for the art therapists working in eating disorder support centres in designing and refining the format, structure, or directives for their groups. Some of the insights gained from this research may also be generalized for eating disorder art therapy groups in other settings, such as treatment programs, private treatment centers or private practice. Positive results may also be used to garner additional funding for the visual art programs in eating disorder support centres, which may translate into more and better quality art materials and more art-based groups, thereby creating more opportunities for those who are interested in the therapeutic benefits of art-making to participate in these groups, as well as generating more work positions for art therapists who are interested in the area of eating disorders.

**RESEARCH OBJECTIVES**

The main objective of this research study is to examine the participants’ experiences of short-term art-based support groups for adults living with eating disorders. Through semi-structured interviews with multiple participants, this study aims to answer the following questions:

**General Question:** What are participants’ experiences of the short-term art-based support group for adults living with eating disorders?
Specific Questions:

1. What did they expect to gain from this experience before joining the group?
2. What have they gained from this experience?
3. Are there aspects of this experience that they find helpful / unhelpful? If so, what are they, and how are they helpful / unhelpful?
4. How does this experience relate to their self-defined sense of well-being and/or recovery process?

A more detailed discussion of the research questions as well as the resulting interview questions will be discussed in the Methodology section of this proposal.

LITERATURE REVIEW

Over the past 20 years, there has been a gradual increase in writings about the use of art therapy in the treatment of eating disorders (Wood, 1996, p.18; Frisch, Franko, & Herzog, 2006, p.132). In the following sections, I will first review the writings that describe the etiology and characteristics of eating disorders. Then, while discussing how my study can fill the gaps in relevant literature in the field, I will examine the literature that focuses on the effectiveness of art therapy and support groups in the treatment of eating disorders.

Characteristics of Eating Disorders

Before delving into the different theories regarding the etiology of eating disorders, it may be helpful to first review the characteristics of different types of eating disorders. As mentioned earlier, the DSM IV-TR has classified symptoms of eating disorders into two main categories: anorexia nervosa and bulimia nervosa (APA, 2000, p.583). Those who show a variation or combination of anorexia and/or bulimia symptoms but do not meet the exact criteria for neither are classified as having “eating disorder not otherwise specified” (EDNOS), which includes a condition that is formerly known as binge eating disorders (p.583). 90% of the cases of anorexia and bulimia occur in females, typically beginning in adolescent or
early adult life (APA, 2000, p.587, 593). While the prevalence of anorexia and bulimia are relatively rare (0.5-3% among the female population) (p. 587, 593), EDNOS are “the most common eating disorders health care professionals encounter in routine clinical practice”, occurring in female and male of different age groups and ethnic backgrounds (Wilson, Grilo, & Vitousek, 2007, p.207-208).

The prevalence of EDNOS suggests that, often, the manifestations of eating disorders are not neatly categorized and may not be easily identified. Weight is not always a reliable indicator of an eating disorder, since those who suffer from it can be emaciated, within a normal weight range, or overweight (Sheena’s Place, 2009). Furthermore, though one may not fit into the diagnostic categories of eating disorders, his/her life can still be significantly affected by disordered eating behaviours, which may include severe caloric restriction, binge-eating, purging through self-induced vomiting or laxative/diuretic abuse, and over-exercising (NEDIC, 2008). However, despite the differences in individual cases, self-esteem is a central concern behind all types of disordered eating behaviours. The self-perception and self-evaluation of individuals who struggle with disordered eating are often highly dependent on their body shape and weight, and they commonly experience high level of dissatisfaction with their bodies (APA, 2000, p.584, 591; Wilson, Grilo, & Vitousek, 2007, p.208). This experience of self-esteem is also tied to the issue of control. Feelings of shame and lack of control frequently accompany binge-eating (APA, 2000, p.594), while methods that may help to avoid weight gain or achieve excessive weight loss are experienced as means to remain in control and as “a sign of extraordinary self-discipline” (p.584). Prolonged periods of food deprivation, however, can trigger compulsive binge-eating, which in turns results in feelings of shame and the need to be in control through self-starvation, thereby perpetuating the vicious cycles of self-damaging behaviours (p.590). Other psychological disturbances that may emerge through disordered eating include depressed mood, obsessive compulsive behaviours, restrained initiative and emotional expressions, social withdrawal, feeling of ineffectiveness, anxiety, self-harming behaviours, and substance abuse (p.585, 591).

The mortality rate of eating disorders has been reported at 18-20% – highest among all other mental illnesses (Cavanaugh & Lemberg, 1999, p.8) and commonly results from cardiovascular problems,
electrolyte imbalance and suicide (APA, 2000, p.588; Bock, 1999, p.42). While people with anorexia typically deny the seriousness of their malnourished state (APA, 2000, p.584), those who binge-eat and/or purge are often ashamed of and are rather secretive about their eating problems (p.590), thus resulting in ambivalence about recovery and delay in treatment in all types of eating disorders (Dolhanty, 1998), thereby potentially increasing the risk of mortality in the sufferers.

This general information about the characteristics and prevalence of eating disorders suggests that many sufferers do not fit neatly into the medical classifications of anorexia or bulimia, and many of whom are also reluctant to seek treatment. The absence of screening instruments and eligibility criteria at the eating disorder support centres therefore makes it possible for anyone who considers him/herself in need of eating disorder support to access the agencies’ resources and services in whatever extent he/she chooses, regardless of diagnoses or the lack thereof (Sheena’s Place, 2000, ch.2, p.4). This system of self-directed participation thus renders the individuals, not a general diagnostic guide, as the experts of their own experiences.

*Etiology of Eating Disorders*

The first theories generated on the etiology of eating disorders seem to be dominated by a psychodynamic perspective, and they are mainly related to sexual disturbances and their resulting inner sense ineffectiveness or “badness” (Levens, 1987, p.2; Bruch, 1988, p.5). As such, “oral gratification, at a primitive level, is associated with sexual pleasure” (Levens, 1987, p.2); food refusal is viewed as “a defence against oral impregnation” (p.2), and the disturbed experience of the self is postulated as being related to maternal deprivation (Levens, 1987, p.2; Schaverien, 1989, p.14). Palazzoli (1974) proposes that eating disorders are results of the female adolescent’s identification with a “bad internalized mother”; the pubertal changes in her body are understood by this adolescent as a direct attack by the bad mother and her attempt to “completely devour her” (as cited in Rehavia-Hanauer, 2003, p.138). Thus, the purging and self-starvation can be understood as a way of ejecting or disavowing the inner “bad” object (Wood, 1996,
p.16). In the same vein, Schaverien (1989) suggests that the anorexic client’s refusal to eat can be understood as an attempt to “evokes the mother’s primitive anxiety” (p.14), while Glucksman (1989) views binge-eating as an attempt to “replace lost or disappointing love objects”, and to “compensate for inadequately internalized maternal functions, including self-soothing and ‘anxiety management’” when negative feelings arise (p.154). Unresolved Oedipus complex is also said to contribute to the unconscious maternal conflicts (Levens, 1987, p.5; Luzzatto, 1994, p.141; Rehavia-Hanauer, 2003, p.138). Levens (1987) reports that she has often witnessed the expression of a “desire to have one parent to themselves, or to get in between the parents” in the artworks of “all groups of eating disordered patients” (p.5).

From a family or developmental perspective, many practitioners have observed that disordered eating often developed as a coping mechanism against external stressors such as life changes, family dysfunctions and sexual abuse (Hinz, 2006, p.25, 114; Orbach, 1978, p.22; Rehavia-Hanauer, 2003, p.138). Lack of impetus and support from the family of origin during individuation-separation in early childhood and adolescent years can lead to a sense of ineffectiveness, which the child attempts to combat by placing extreme restrictions on his/her body and food intake (Rehavia-Hanauer, 2003, p.138). Hinz (2006) connects family dysfunctions to personality traits and contends that individuals who suffer from eating disorders have often been caring, sensitive, intelligent children who neglect their own needs when their parents inappropriately rely on them to understand complicated relationships or to meet parental needs (p.25). As a result, these children use food or the control of food and their bodies to cope with the overwhelming, painful feelings arising from chaotic family situations and the deprivation of emotional nurturance (Hinz, 2006, p.25; NEDA, 2008; Rehavia-Hanauer, 2003, p.139). In addition, it is observed that eating disorder symptoms do not only serve as a means of adaptation for the sufferer, but they also function for many families as a way to avoid interpersonal conflicts or confrontations (Levens, 1987, p. 3). Moreover, in the case of sexual abuse, the disordered eating is often used by the victims to gain a sense of control over the pain and trauma of the incidences (Hinz, 2006, p.114; Makin, 2000, p.65).

Feminist writers place the roots of disordered eating in context of the patriarchal society, which
continues to condition women into believing that their contentment resides within the realm of family and caretaking (Orbach, 1978, p.23; Chernin, 1985, p.xiii). Thus, a woman becomes alienated from her body because she must use it, constantly criticize it, control it, and fit it into the culturally approved thin body ideal – a picture of femininity that is attractive to men and therefore increases the likelihood of marriage (Orbach, 1982, 164). As a result, food takes on paradoxical meanings for a woman. As a nurturer, she can use food to live out that socialized, ingrained sense of purpose in her life through providing and preparing it for others (p.164). However, it becomes a dangerous entity when it enters her body, because the society, mainly through the media, has convinced her that food can make her fat and unattractive; consuming it without care can make her seem greedy, lack of control, and unfeminine (p.24, 164-165). As such, both overeating and self-starvation are conscious and unconscious ways through which women respond to as well as protest against their social role and “the packaged sexuality” around them (Orbach, 1978, p.124; Orbach, 1982, p.165). Furthermore, this socialized, oppressive, internalized notion of femininity and the thin body ideal is often passed down from parents to children of both genders (Orbach, 1982, p.164; Hinz, 2006, p.108). In fact, social conditioning has been associated with the occurrence of eating disorders in males. While eating disorders in homosexual men are found to be influenced by the cultural belief that one must be slender to be attractive to men (Atkins, 1998, p.xxi), men with eating disorders in general are reported to demonstrate body image concerns that are related to a thin but muscular physique (Hinz, 2006, p.24).

Treatment of Eating Disorder: Art Therapy and Support Groups

Over ten years ago, Wood (1996) commented that art therapists who wrote about eating disorders “tended to concentrate on describing why art therapy may be effective, rather than on evaluating whether it really is” (p.18). Ten years later, a systematic review of literature conducted by Frisch, Franko, and Herzog (2006) still finds that “while published narrative reflections on arts-based therapies and eating disorders imply a generally positive outcome, no known, empirically valid studies exist on this experiential form of
therapy within the area of eating disorders” (p.131). Moreover, in relations to my proposed study, I have found that almost all of the art therapy literature on eating disorder is based on clinical practices, such as group therapy in hospitals, residential treatment programs, outpatient clinics, or individual treatment sessions in the art therapists’ private practice. I have not found any published literature that focuses specifically on the effects of art therapy or art-making in a non-clinical, non-treatment support group setting for people with eating disorders. Furthermore, I notice that while art therapists often postulate how certain approaches can help individuals with eating disorders by discussing their own perspectives, formulations, and clients’ comments about the specifics of the artworks, only one paper (Hendel & Levick, 1992) has included the client’s comments about her experience with art therapy and how it has been helpful in her process of recovery. My proposed study aims to fill these gaps in the literature by focusing on the clients’ own words about their art-making experience in support groups – an area of eating disorder support that seem to serve a great need but has not been studied in depth in art therapy literature.

This is not to say that I do not value the perspectives and formulations of the art therapists who have had many years of experience in the field of eating disorders. In fact, it has been tremendously helpful to read about how art therapy has been used to treat disordered eating through different theoretical perspectives. From a psychodynamic perspective, Kramer’s notion of “art as therapy” has been regularly referenced by art therapists to explain how the art-making process and the art product can be beneficial in helping eating disordered clients improve their self-esteem (Fleming, 1989, p.280; Hinz, 2006, p.124; Makin, 1994, p.27), which is a central issue in the development and maintenance of the illness. The unrelenting feelings of ineffectiveness commonly experienced by eating disordered clients can be countered by the mastery and sense of control that are developed through exploring different art materials (Fleming, 1989, p.282; Makin, 1994, p.27). In a deeper sense, Fleming (1989) also suggest that the art product can serve as a “self-object” and a “transitional object”, through which the soothing experience of the art-making process and the uniqueness of what is made can provide a “corrective experience leading to a gradual internalization of soothing and confirming functions” (p.281). Using the term “transactional object”,
Schaverien (1989) further theorizes that art therapists can offer art to the clients to replace food as an alternate, more adaptive method of negotiating with the external world (p.15). Similarly, Luzzatto (1994) suggests that positive relationships between the client, the artworks and the therapist can promote a variety of positive patterns of relating with the outside world and the self (p.142). On the other hand, the use of art materials may also stimulate free expressions of unacceptable impulses or intolerable feelings about the self (Fleming, 1989, p.282; Levens, 1987, p.3). Hinz (2006) echoes this concept of free expression by hypothesizing that, since many people with eating disorders often over rely on verbal defense mechanisms such as rationalization and intellectualization, art therapy is more effective than verbal therapy because it has the capacity to “bypass language-based defenses to reveal inner truths” (p.9-10). Makin (1994) reasons that since eating disordered clients are usually attracted to and are very comfortable with art activities, simply messing and playing with the art media can be a nonthreatening, pleasurable way through which clients can slowly let go of their rigid control (p.27). However, Levens (1987) cautions that, in order to promote internal change, the therapist may need to offer some structure or directives for the clients to reflect on the underlying meanings of their expressions; otherwise, allowing uncontained outpours of emotions in art therapy may perpetuate the acting-out behaviour of “taking things in and vomiting things out” (p.3).

Drawing on the principals of cognitive behavioural approach – an approach that is demonstrated by empirical research as one of the most effective treatment methods for eating disorders – Matto (1997) proposes that the use of specific directives in art therapy can help clients safely explore and express previously avoided emotions, create order out of chaotic feelings, challenge maladaptive behaviour, and replace negative self-statements with empowering self-affirmations (p.349). It is hypothesized that concrete images created in art therapy can offer clients opportunities to confront their body image or cognitive distortions in a tangible way (Makin, 1994, p.27; Matto, 1997, p.350). In regards to reducing maladaptive behaviours, Hinz (2006) suggests encouraging clients to draw in their journals in between therapy sessions to reduce anxiety, promote relaxation, and to distract themselves when the urges to
engage in disordered eating behaviour arise (p.88).

Many directives that Hinz (2006) has developed also focus on externalizing the eating disorder through image-making, since clients with eating disorders tend to identify themselves with the illness (p.45). She emphasizes that in order to create lasting, meaningful changes, the clients must first realize that they are not the eating disorders, and that the eating disorder is a separate entity that they can deal with effectively (p.45). Hinz’s ideas seem to echo the narrative approach in the treatment of eating disorders, which aims to help individuals construct their own preferred way of life and identity through externalizing, understanding, and defying the eating disorders (Linn Maisel, Epston, & Borden, 2004). This externalizing approach has also been incorporated by Matto (1997) in art therapy groups, in which exercises such as magazine collage can facilitate discussions about the cultural messages that perpetuate group members’ negative self-perception, promote connections between participants to normalize and validate each other’s experiences, and inspire artworks that seek to actively defy these cultural messages (p.351).

Hinz (2006) comments that the general group therapeutic factors identified by Yalom (1995), such as imparting information, universality, altruism, and the instillation of hope, are particularly applicable to eating disordered clients because of the shame, secrecy, feelings of ineffectiveness and relational difficulties that characterize the illness (p.172). For the eating disordered clients, not only does the group become a microcosm where they can try out new, assertive behaviour and receive feedback from their peers, it is also a community in which those who are new to treatment may receive support and validation and gain a sense of hope from those who are in later stages of recovery (Hinz, 2006, p.172; Makin, 2000, p.157). Some worry that the competitive nature of eating disorder may undermine the benefits of art therapy groups; however, Makin (2000) has observed that once the clients are engaged in their own work, they are seldom distracted by other group members (p.156). In fact, since individuation-separation has been identified as a central issue that contributes to the development of eating disorders, the individual art-making and corporate processing of artworks can provide group members with the opportunity to experience what it is like to be part of a group and a unique, separate individual at the same time (Hinz,

The community-based, non-treatment support groups and open art studios may also be understood as embracing some of the person-focused and political aspects of narrative therapy. Referring to the founding principles of the Open Studio Project, a community-based art studio for disabled individuals, Allen (2008) writes, “[by] stepping out of the world of art therapy and its language of ‘treatment,’ ‘therapy,’ and ‘diagnosis,’ we were making an essentially political statement that creativity is more closely aligned to an individual’s health than to any disease process” (p.11). While there are “no efforts to fix, cure, change, or interpret”, the participants provide a nonjudgmental “witnessing community” that supports their autonomous creative expressions as well as their “shared engagement with the stuff of life” (p.11). Similarly, Block, Harris and Laing (2005) aim to minimize the therapist/client power relationship in the open studio that they run for at-risk youth by employing a model in which “the client and facilitator work alongside each other as fellow artists” (p.34). Integral to this egalitarian model are the principles of self-direction and non-judgment. In the open studio, the youth are free to make their own choice about whether or what they would like to share about their artworks, while group members are asked to refrain from critiquing or commenting on what is shared, thereby increasing the youth’s “sense of safety, confidence, and personal responsibility” (p.37). Block et al. have observed that by voicing and externalizing their problems, the youth are able to “challenge the misconceived views of their problems so embedded in public perception”; the art-making is therefore not only a personal expression but also a means of social action (p.37). In the area of eating disorder, Matto (1997) also feels that it is important to incorporate community activism into the treatment process, and that one way of facilitating social action is to organize exhibitions of artworks made by individuals in recovery (p.352). She believes that through the exhibition the clients’ experiences and skills can be honoured and celebrated, and the community sharing of images and stories can “weaken the power of the eating disorder” by exposing the problem as well as the media messages and gender socialization that perpetuate it (p.353).
Finally, it is worth noting that while many art therapists seem to be convinced of art therapy’s effectiveness in the treatment of eating disorders, they also strongly recommend employing it as an adjunct therapy rather than a stand-alone one (Levens, 1987, p.3; Makin, 1994, p.27; Matto, 1997, p.347; Schaverien, 1989, p.16). After all, eating disorder is a complex, multifaceted illness that affects all areas of life; other methods of support such as ongoing medical care, nutritional counseling and family therapy are sometimes not only helpful but critical for the client to work towards recovery. Used in the context of other treatment methods, art therapy may help clients express, explore, and integrate the feelings, learning, and insights gained from other therapies or areas of life (Makin, 1994, p.27).

Theoretical Orientation

Even though eating disorder support centres do not provide therapy for their clients, I do believe that the clients can still experience the therapeutic benefits of art-making through art-based support groups. Like traditional art therapy, the art media in a support group setting can facilitate self-expression and possibly reduce the power of perfectionism and the need to control, while the themes and directives that are often structured into the art-based support groups (Danielle’s Place, 2005; Hope’s Garden, 2008; Sheena’s Place, 2009) can provide a framework for the clients to safely contain their feelings. A sense of balance and community involvement may also be facilitated when clients attend the art-based support groups in conjunction with other outpatient treatments. Because these support centres are not treatment oriented, the art-based support groups can offer the clients an opportunity to step out of the realm of treatment and therapy and transition back into the community in which they live, while still being in the company of people who share and understand their struggles. Since the focus of these agencies is mutual support rather than using treatment techniques to create changes in the clients’ behaviours, the art-based support groups may seem even less threatening to the ambivalent clients than traditional art therapy offered in a clinical setting. Indeed, self-direction, self-motivation and freedom of choice are key components of the art-based support groups. Participants do not remain in the group because they have
submitted payment to secure a spot in the treatment program, or because art therapy is part of the treatment plan and one must attend to remain in the program; participants remain in the group because they choose to. Those who are conditioned to taking care of others’ needs before their own are in a way *choosing* to take some time for themselves, to give themselves the opportunity to discover their own brilliant creativity and uniqueness, to move away, at least for the duration of the group, from the self-harming eating disorder behaviours to engage in a soothing, explorative, expressive activity that may help them heal. I would hypothesize, therefore, that the art-making process in an art-based support group can be experienced as an opportunity to practice self-care, which may in turns help them sustain a healthier self-perception and lifestyle in recovery. Though there are currently no published art therapy research that can validate the effectiveness of art-based support groups for people with eating disorders, an eating disorder support centre in Toronto has commissioned two quantitative studies to evaluate the effectiveness of its programs. The study results indicate that there is a significant relationship between attending an art-based support group and an increased level of hope in the participants (Sheena’s Place, 2004), and that majority of the art-based support group participants have reported improvements in regards to their eating-related and body image issues as a result of their participation (2000).

However, my hypothesis is an educated assumption at best, and quantitative data do not tell us *what* aspects of the art-based support groups they find helpful and *why*. For this reason I am inclined to borrow ideas from narrative therapy to conduct this proposed study. While I agree that all of the theoretical formulations I have included in the literature review can be possible underlying causes of or effective treatment methods for eating disorders, I believe that they are only valid in individual cases if the individuals *choose* to include these theories as a part of their own realities. I would go as far as to say that if we attempt to impose any one of these theories and formulations onto our clients without their agreement, we are being as oppressive as the eating disorders that tell them not to eat, or the society that tells them they must be thin to be accepted. Central to the participation in an art-based support group is freedom of choice; people choose to participate in these groups and express themselves in any way they
choose, to any extent they choose. I would like my research approach to match what it is that I am studying by inviting the participants to share their experiences and construct their own meanings. Thus, I have chosen to employ informal interviews with open-ended questions rather than structured questionnaires with predesigned categories. As well, I have borrowed from phenomenological research methods in the design of my research inquiries in order to formulate questions that focus on the participants’ experiences and their meanings (Creswell, 1998, p.53). The phenomenological technique of “bracketing” – to first acknowledge and then set aside my own prejudgment and experiences related to the research topic (p.52) – will also be employed during the data collection and analysis in this study. It is my hope that, through this study, the voices of those who have been oppressed by eating disorders will be heard, and by sharing and using our experiences to understand and improve our techniques of support, we will be actively fighting against and weakening the oppression of eating disorders.

**METHODOLOGY**

**A. Sample**

The participants will be recruited from a Toronto-based eating disorder support centre. I aim to interview 5 – 10 women between 18 to 65 years of age who identify themselves as living with an eating disorder, and have participated in at least 3 sessions of an art-based support group offered at the agency within the past year. These criteria are mainly determined by the client base and the general trend of group participation at this particular support centre. Because this agency does not offer groups for adolescents, and the vast majority of the clients are female, I expect the participants of this proposed study to be exclusively adult women. Through discussions with the administration staff and group facilitators, I have also learned that participation rates in all groups are often unstable and, while all art-based support groups offered at this agency are 8 weeks long, it is common for participants to stop attending after a few sessions, and to return at a later time to participate in a different group. In order to maximize the sample size for this study and at the same time collect adequate, recent information about the participants’ experiences of the
groups, I have decided that participants in this study must have attended at least 3 sessions of an art-based support group within the past year.

That said, it will be very helpful if a substantial portion of the data is collected from participants who have experienced the full duration of the group. Thus, a letter describing the purpose of this study and my contact information (Appendix A) will be handed out by the facilitators to the participants in the final session of the art-based support groups. This letter will also be posted at the agency’s bulletin board, and handed out to individual participants as they retrieve their artworks from a recent art show held at the agency, so that those who are not currently participating in art-based groups but have participated over the past year will also receive information about this study.

B. Interview Process

The interviews will be approximately 1 – 1.5 hours long, and will be held at mutually convenient locations for the participants and the interviewer (me), such as the support centre or the participants’ homes. Each participant will be interviewed once. The interviews will be tape recorded and notes will also be taken during the interview. Participants will be invited to bring to the interviews artworks that they have made in the groups, especially the ones that they find best represent their experiences of the groups. Before the interview begins each interviewee will be asked to sign a consent form that clarifies disclosure and confidentiality issues (Appendix B). There is no compensation for participating in the interviews; however, participants will be reimbursed with public transit tokens if applicable.

The interview questions are derived from the research questions mentioned earlier in this proposal (see Research Objectives). Essentially, they aim to answer this research question: What are participants’ experiences of the short-term art-based support group for adults living with eating disorders? Particularly, I would like to gain some understanding about how their experiences in these groups relate to their self-defined sense of well-being and/or recovery process, because I think it would be helpful to investigate whether these groups can provide lasting benefits, or if they are only able to offer temporary
support, such as distraction from the urges to engage in self-destructive behaviour for the duration of the group. I have chosen the term *self-defined* for the research questions because I do not want to define for the participants what well-being means to them; rather, I would like to hear from the participants what it means for them to be or feel well. Also, I understand that while recovery is a goal for many people, some are ambivalent about recovery or simply do not wish to recover. Thus, by using the terms *self-defined sense of well-being* as well as *recovery* I hope to demonstrate a nonjudgmental and respectful attitude towards all participants.

The interviews are semi-structured, and will be conducted in a casual, conversational manner. The interview questions will begin with discussing basic information about the groups that the participants have attended, and then move into their subjective experiences of the groups.

1. What group did you participate in? Were there specific themes or art techniques involved?
2. How many sessions did you attend in this group?
3. What did you expect to gain from this group when you signed up for it?
4. Can you describe your experience in this group?
   If the participant has brought artworks, she will be invited to share anything she would like about the artworks. More specific questions will be asked if the participant does not mention the following:
   a. What do you think about the facilitator?
   b. What do you think about the format of the group (i.e. directives or the lack thereof)?
   c. What do you think about the group dynamics (i.e. making art with a group of people, sharing, helping one another with their art-making, etc.)?
   d. Are there aspects of this groups that you find particularly helpful / unhelpful? If so, what are they, and how are they helpful / unhelpful?
5. Do you think you have gained anything from this experience? If so, what have you gained?
6. What do you think this group has done for your sense of well-being and/or recovery process?
C. Analysis

The data analysis of this study will be guided by the framework outlined in Lofland and Lofland (1984) and the phenomenological approach described in Creswell (1998). The audio records of the interviews will be transcribed, and the participants’ statements will be coded and categorized; at the same time, memos will also be written and categorized (Lofland & Lofland, 1984, p.131-135). The phenomenological research technique of “bracketing” will also be employed to minimize the effects of my own prejudgment on the data collection and analysis process (Creswell, 1998, p.52). Documents generated for the groups, such as group descriptions written facilitators, group norms, handouts for the exercises, etc., may also be included to enhance my understanding of the group process and analysis of the participants’ statements. Through abstraction, general themes and meanings will be extracted from the coded statements and memos with the aim to form a comprehensive narrative that describes the participants’ experiences of the art-based support groups and the meanings they ascribe to these experiences (Creswell, 1998, p.55). As such, data collection and early stages of analysis will occur simultaneously, but the final abstraction of general themes and meanings will not be carried out until the data collection is complete.

D. Timeline

I plan to distribute the information letters at the support centre in August, 2009. Depending on responses, interviews may begin as early as September, 2009 and continue until the end of March, 2010. Final stages of analysis and the writing of the thesis report will take place from April to July, 2010.

E. Anticipated Challenges & Possible Solutions

1. Lack of responses

By the end of January, 2010, if fewer than 3 interviews have been conducted, and if majority of the participants choose not to bring their artworks to the interviews, I may explore other methods of collecting data that are perhaps less time consuming than in-depth interviews. These methods may involve brief
group interviews or written interviews to be conducted in the final sessions of the groups, or obtaining permissions for email or phone interviews. I may also incorporate information collected from another art-based support group at a different eating disorder support centre in this proposed study. I have observed and co-facilitated this group as a placement student from January to March, 2009; five women participated in this group, and appropriate consent forms were signed by all group members. The content of each session had been logged and all artworks were documented. In the final session a brief group interview was conducted with the question: “What have you gained from this group?” and the participants’ answers were recorded. I may analyze the data collected from this practicum using the methods described in the Analysis section of this proposal, and present the results in the final thesis report alongside results from the interviews.

2. Generalization

The major limitation of this study lies in the issue of generalization, and it can affect the study on several different levels. First, the results generated from this study may not apply to adolescents and men living with eating disorders because all participants in this study will be adult women. Secondly, the interviews are conducted in one eating disorder support centre only; the experiences of participants in other eating disorder centres may differ from those in the study because of variables such as location, accessibility, policy, etc. Finally, within the study, because participants from different groups will be interviewed and because the sample size will be small, the participants’ responses may also vary greatly due to their experiences of the different group themes or the group leaders’ facilitation style. Thus, it may be difficult to formulate general statements that can adequately represent these highly individualized and diverse experiences.

However, I think that, to some extent, all human experiences are highly individualized, diverse, and difficult to generalize. To me, the beauty of informal interviews is that we have the opportunity to ask the “why” and “how” questions, to understand the complex context around which specific statements are made. In this regard, the participants’ responses can be different or even contradictory, but they are by no
means invalid or unimportant or unfounded. In the case of the art-based support groups, seeing a wide range of experiences can challenge or confirm the facilitators’ assumptions about what is or is not helpful to those they are attempting to help, so that they may adjust their approaches accordingly. More importantly, the diverse responses make clear the fact that the interviewees are not “the eating disorder population” but are *individuals* living with eating disorders. It is vital for service providers and clients alike to recognize that those who are living with eating disorders are much more than their eating disorders, that their uniqueness perspectives, knowledge and wisdom should be valued and celebrated, and that they have so much to contribute to the fight against eating disorders.
D. How this Study Meets the Requirements of the TATI Research with Human Subjects Policy

It is stated clearly in the participant consent form (appendix B) and it will be explained to the participant before the interview that some of the issues discussed in the interview will be of a personal nature, but at this time there is no foreseeable risk or harm to the interviewee in participating in this study. At the same time, it will also be explained that there is no foreseeable benefit to the interviewee in participating in this study; however, the insight participants share will help me, an art therapy student, and possibly other art therapists and service providers gain a better understanding of the effects of art-making in a non-treatment setting for people with eating disorders.

A legally effective consent form (appendix B) will be signed by both the researcher (me) and each participant in this study. In addition, a revised TATI consent form will also be signed by both parties plus a witness. Revision will be made on the form to replace the terms related to “art therapy sessions” with terms related to “research study”, because this proposed study does not involve providing art therapy sessions to the participants. The signed consent forms will be kept in a locked cabinet in my home and will be destroyed upon the completion of the study. It is also stated in the consent form and will be explained to the participants that they may withdraw from the study at any point with no penalty.

I will respect the rights and privacy of the participants at all time, and will ensure that maximum confidentiality of all personal information will be maintained. The audio recordings of the interviews will be stored in my personal, password-protected computer, and the transcripts and all other documentations of the study will be kept in a locked cabinet in my home. The recordings will only be heard by me, and they will be erased upon the completion of the study. In all documentations of this study all personal identifiers will be removed and each participant will be represented by a single letter in her name. These measures regarding participant confidentiality are stated in the consent form (appendix B).

When recruiting the participants I will distribute information letters to groups and post the letter on a bulletin board at the support centre. While interested clients are invited to contact me, I will not contact individual clients by phone or email to elicit participation. When interested clients contact me, I will make clear that they can freely choose to participate. I will also explain that there is no benefit or risk in participating in this study, and there is no negative consequence in choosing not to participate. During this initial contact I will also assess whether the clients are stable medically and psychologically; those who may be at risk of being medically or psychologically unstable will not be interviewed. I will also inquire if the participants are attending support groups or therapy sessions outside of the support centre to ensure that they have adequate support if they need to deal with issues arising from the interviews. It is stated in the consent form and I will also make clear to the participant that they can contact me anytime with any question or concern they have about the study, and they may request that any information from their interviews not be included in the study. Should a participant present in crisis, I will provide the participant with the numbers for the Gerstein Centre in Toronto and remain with the participant when she makes the call if necessary.
REFERENCE


Thesis Proposal:
Exploring Participants’ Experiences in Short-term Art-Based Support Groups for Adults with Eating Disorders

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July 8, 2009

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