Arts Therapies for Eating Disorders

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Contributor: Music Therapy Associaton of Republic

Eating disorders (EDs) are mental illnesses that cause serious disturbances to people's everyday diet. Since EDs are on the rise throughout the world, healthcare policies and practitioners need to research different treatment options and their affectivity, value for patients, and cost effectiveness, in order to make any substantial change to the growth of this disease.

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1. Introduction

Once seen as a westernized condition, the shift of EDs into the global population is accelerating [1][2][3]. Erskine et al. [4] states that the inclusion of EDs in the Global Burden of Disease Study (GBD) is a milestone in the recognition of the wider health issue affecting the global community. The Smink et al. [5] review of the worldwide epidemiology of eating disorders states that anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), combined, ranked as the 12th leading cause of disability-adjusted life years (DALYs) in females between the ages of 15–19. Epidemiological studies show a clear increase in the prevalence of EDs over a study period, from 3.5% for the 2000–2006 period to 7.8% for the 2013–2018 period, which seems alarming [6]. According to the National Eating Disorder Association (NEDA) [7] up to 30 million people in the United States alone suffer from an ED. Furthermore, Qian et al. [8] found that EDs are more common in Western countries compared to Asian countries [8].

Currently there are many discussions as to why we are experiencing such a growth in ED cases. Grave [9] suggests there are various and combined causal factors such as psychological, sociocultural, biological, or family factors. People of all ages and genders, as well as cultural backgrounds, can be affected by an eating disorder [10]. On one hand, experts are partly attributing the increase to a greater awareness of the wide range of disorders and the changes in diagnostic criteria [8]. On the other hand, shifts in populations and cultural influences, the advances in technology with the surge in social media and the focus on body shape and gender roles, combined with the questioning of traditional family and work structures are contributing to changes in what is seen as healthy eating and a healthy body image.

EDs can manifest as eating extremely small amounts of food or severely overeating. The National Health Service (NHS) [11] terms EDs as an unhealthy attitude to food; an attitude by which the focal point of a person´s life is their relationship to food. In addition to maladaptive eating patterns are concerns, even obsessions, around weight and body shape/image. These behaviors are classified as mental health illnesses not because of the significant impact on the body's ability to get appropriate nutrition, but because of the psychological distress, fear of gaining weight, distorted body image, and excessive exercise, which then categorizes the ED as a biologically-influenced medical illness [12]. Further evidence shows that eating behaviors are affected by emotional regulation. Specifically, higher levels of alexithymia, a personality trait characterized by an inability to modulate and identify one's feelings and body sensations, were found in overweight persons [13]. Alexithymia frequently co-occurs with depression, anxiety, social phobia, and substance abuse, all of which are disorders which often overlap with an ED.

Eating disorders have their own specific diagnostic criteria according to both major diagnostic manuals. The American Psychiatric Association's fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) provides diagnostic criteria for pica, rumination syndrome, avoidant/restrictive food intake disorder, AN, BN, and BED [14]. The tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) by the World Health Organization provides slightly different diagnostic criteria for EDs [15]. ICD-10 recognizes diagnostic criteria for AN, atypical AN, BN, atypical BN, overeating associated with other psychological disturbances, vomiting associated with other psychological disturbances, and other eating disorders. It is common to observe migration between ED diagnoses as well as frequent use of unspecified eating disorder diagnoses [9], however, AN and BN are known as the most predominant eating disorders.

Studies point out that EDs have, in recent years, had the highest mortality risk among other psychiatric diagnoses [5], however the exact mechanism for how a person's susceptibility to an ED might work is not fully understood. Research in general concurs that a combination of genetic, biological, behavioral, psychological, and social factors can raise a person's risk [9]. Although an ED can be developed at any age, the National Institute for Health and Care Excellence (NICE) reminds us that the highest risk of development is seen in young women and men between 13 and 17 years of age [2]. Certain psychological factors and personality traits which develop during these adolescent years may predispose a person to an eating disorder [14]. Neuroticism, obsessiveness, and perfectionism can play a large role in facilitating EDs, particularly AN and BN. Individuals with these personality features are prone to anxiety and depression, and display perfectionistic and self-critical tendencies, all of which are factors that may contribute to their difficulty managing their weight and eating in a healthy manner [7][14]. Fassino et al. [16], in their controlled study of the temperament and personality of eating disorder patients, state that those diagnosed with AN tend to have high levels of harm avoidance, characterized by worrying and pessimism, and low levels of novelty seeking, characterized by a rigidity in thinking and an unwillingness towards new experiences. Individuals diagnosed with BN also show high levels of harm avoidance, but instead is it combined with high levels of novelty seeking, which is linked to the lack of impulse control associated with binge–purge behaviors [16].

For some years now it has been suggested that a developmental understanding of disordered eating would be greatly enhanced if we were to look through the lens of developmental psychopathology, more specifically the clarity and distortions that emerge from primary relationships [17]. An insecure attachment is the key risk factor to developing an ED. Attachment theory, originating from the work of Bowlby [18], offers a comprehensive framework for understanding the potential individual and family characteristics which contribute to the development of an ED. Furthermore, it provides an insight into a range of different psychological functions like emotion regulation and interpersonal functioning, which are associated with EDs [19]. Mantillia et al. [20] and Gander et al. [19] extend this point by arguing that the relationship a person has with their eating disorder is shaped by that person's understanding of what meaningful relationships should look like, this in turn has important consequences on the severity of their disorder.

Mantillia et al. [20] uses "attachment theory" to establish a link between the attachment to a significant other and the attachment to an ED. The study group researched consisted of 148 women with EDs aged from 16–25 in an outpatient setting in Sweden. ED behaviors were measured by questions looking at the regularity and the relationship of the ED to the patient. The findings showed that the less securely attached individuals experienced their ED as more in control, and themselves as less autonomous [20]. Findings from Gander et al.'s [19] study of research and literature that used a narrative-based methodology in the field of EDs in adolescences, showed a high prevalence of unresolved attachment status caused by possible abuse. So instead of choosing to be close to someone consistently, this adult attachment behavior in the patient escapes consistently into the ED in order to overcome the emotional/physical injury. A plausible link can therefore be made from this data which suggests that insecure and unresolved (disorganized) attachment types produce a tendency to internalize unexpressed emotions and the expectation of a controlling relationship which in turn produces disordered eating symptoms as a means to survive and manage the unhealthy relationship.

The treatment of EDs is one of the most difficult among other psychiatric disorders. Currently there is a large spectrum of therapeutic approaches and a strong therapeutic alliance between therapist and patient is emphasized [21]. Various forms of cognitive behavioral therapy (CBT) are widely used [21][22]. Enhanced cognitive behavioral therapy (CBT-E) was specifically developed to maintain eating disorder psychopathology and studies support its efficacy and effectiveness [23] [24]. Another approach offers cognitive remediation therapy (CRT) which focuses on core cognitive processes [25]. Some of the newer approaches in the treatment of EDs are the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), as well as specialist supportive clinical management (SSCM). SSCM combines features of clinical management and supportive psychotherapy [26]. After unsuccessful application of CBT, MANTRA, or SSCM, eating-disorder-focused focal psychodynamic therapy (FPT) is applied [2]. A family-based approach for children and young people with EDs which shows promising results especially at follow-up care, and according to given evidence may be more beneficial than individual therapy [25][27]. Medication should not be offered as a sole treatment for AN, BN, or BED [2]. However pharmacotherapy is frequently prescribed in combination with CBT or other psychotherapy as a means to help decrease other psychological symptoms such as anxiety or depression [25][28]. At this stage it is challenging to describe the efficacy of each treatment approach. Outcomes of residential care in various studies reported positive results of in-patient treatment, however the difficulty remains in identifying which approach provides the most efficient outcomes since each program combines them differently [29].

2. Arts Therapies and Their Modalities in the Treatment of Eating

Disorders

Arts therapy (AsT) disciplines which have been developed as the result of multidisciplinary efforts between artists, psychotherapists, educators, and social/health workers share common characteristics, namely the value they each place upon creativity. They each share an appreciation of the non-verbal aspect of communication and understand the use of imagery, symbolism, and metaphor as a link to psychological/emotional states. They acknowledge the need to work safely in the presence of a secure therapeutic relationship, guided with interventions that are based on the therapeutic aims of the specific individual as well as the client population [30].

A central premise of the AsTs is that any individual regardless of ability, disability, illness, or health can engage creatively in the arts and use them to help restore health and well-being. It is this open position to engage creatively that gives AsTs a unique contribution to the treatment of EDs. AsTs (also creative therapies (CTs), or creative arts therapies (CAsTs)) are defined as “the creative use of the artistic media (visual art, music, drama, and dance/movement) as vehicles for non-verbal and/or symbolic communication, within a holding environment, encouraged by a well-defined client–therapist relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual” [30] (p. 46). Apart from the main four types/specializations of AsTs (namely art therapy, music therapy, drama therapy, and dance/movement therapy), there is also an intermodal approach defined by Knill [31] called expressive arts therapies. Comparative research focusing on the unique contribution of every artistic media is needed for the further development of AsTs as a treatment intervention in the field of EDs.

EDs are present in both genders and in those with a more fluid understanding of gender, however to date EDs are more prevalent in the female population. To address gender aspects in the AsTs it is perhaps timely to mention the influence of feminist and post-feminist theories on the work with the female population in AsT practice. Approaches that lean towards exploring the social and cultural context of a person with an ED often have their roots in feminist theories as a way to gauge a broader perspective of issues that are directly linked to women. For instance Dokter [32] in her drama therapy (DT) practice identified that patients with an ED using DT as a treatment intervention are more likely to be female, and thus interventions/methods should reflect gender differences.

Compared to traditional verbal treatments, AsTs are described as non-verbal, creative, expressive, and experiential (action oriented). The creative process on a non-verbal level may lessen defense mechanisms, rationalization, intellectualization, and persuasion tendencies that are frequently used by patients with EDs when describing their symptoms and feelings on a verbal level [33]. The same defense mechanisms used by the patient to protect the self and provide a sense of control are often replicated in verbal psychotherapy. Reliance on rationalism, intellectualization, or arguments about the patients’ intimate relationships with food can slow the verbal psychotherapy process and stop patients from processing their emotions on a deeper level [34]. AsTs allow patients to work with other parts of their bodies through various methods and techniques such as playing music, painting, movement, or role-play. The shift to a more “right brain” creative approach which facilitates the psychotherapeutic use of music, art, movement, and drama opens the door for the patient to shift from explaining their feelings into actually feeling them. Alternative means of expression such as metaphors can build a bridge into a deep awareness that may be missed in a more verbal treatment. Plus the engagement of other body parts in the treatment of EDs can be crucial for patients’ reconnection with their bodies, as well as facilitating a better understanding and expression of emotions [10]. Although the argument for the use of creativity and non-verbal expression is both a valuable and practical resource that offers countless applications and interventions, there must also be a clear understanding of the possible risks. Physical activity as a compensation mechanism is a clear risk factor for patients who use exercise to lose weight, and therefore dance/movement therapy could be a more detrimental than helpful treatment path for the patient. As with all AsTs the therapeutic aim and intervention of the treatment must reflect the not just the ED but the individual.

As mentioned earlier, music therapy (MT), art therapy (AT), dance/movement therapy (D/MT), and drama therapy (DT) are the main four types of AsTs. Each approach has its own definition, specifics, methodology, and techniques. Since the careful description of each type of art therapy is required in more detail.

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