# INTEGRATING TRAUMA-INFORMED ART THERAPY INTO PARTIAL HOSPITALIZATION PROGRAMS FOR ADOLESCENTS WITH ANOREXIA NERVOSA: A THEORETICAL INTERVENTION-BASED RESEARCH STUDY

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**ABSTRACT**

INTEGRATING TRAUMA-INFORMED ART THERAPY INTO DAY HOSPITALIZATION PROGRAMS FOR ADOLESCENTS WITH ANOREXIA NERVOSA: A THEORETICAL INTERVENTION-BASED RESEARCH STUDY

JENNIFER KAR WEI LEE

This paper seeks to explore the application and integration of trauma-informed and attachment-focused art therapy with adolescents with anorexia nervosa in a partial hospitalization program setting. The primary research question is: How can a trauma-informed art therapy group program be designed to support adolescents with anorexia nervosa within a multidisciplinary partial hospitalization context? This paper will also address the following subsidiary questions: 1) What might a trauma-informed art therapy group in this population and setting look like? and 2) What are the current best practices and barriers to integrating art therapy within multimodal treatment teams for eating disorders in hospital settings? Research questions are explored using a theoretical intervention research methodology to construct problem and program theories that contribute to the development of both a theoretical foundation and a practical understanding of the factors influencing and mediating treatment for this population. Literature from interdisciplinary fields and diverse sources will be examined and analyzed using a narrative synthesis to assess the current needs and inform the development of an 8-week group art therapy intervention employing a trauma-informed and phase-based approach. This exploration sheds light on the intersections of trauma, attachment, anorexia nervosa, and art therapy. Recommendations for further research including future pilot studies to improve findings are highlighted.

*Keywords*: eating disorders, anorexia nervosa, intervention, trauma-informed art therapy, attachment, adolescence

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# Chapter 1. Introduction

In the intricate landscape of adolescent mental health, anorexia nervosa (AN) emerges as a complex challenge both in the realm of mental and medical illnesses. The profound impacts of AN on both the mind and body necessitate innovative therapeutic approaches that delve beyond conventional methods. Within this realm, art therapy (AT) emerges as an adjunct and multifaceted intervention, offering a unique avenue for adolescents with AN to navigate their journey toward recovery.

Despite the use of various evidence-based treatments for adolescents with AN, this eating disorder (ED) still carries significant challenges including high rates of mortality (Arcelus et al., 2011), prevalence (Agostino et al., 2021), treatment expenses (Stewart & Williamson, 2004a; van Hoeken & Hoek, 2020; Lester, 2019), and psychosocial burdens (Hay et al., 2014). As a result, multidisciplinary team approaches to treatment within partial hospitalization programs (PHPs) have proven essential (Seubert & Virdi, 2018). A scoping systematic review of PHPs for adolescents with EDs revealed that 69% of existing treatment models for adolescents were largely family-based therapies, and of the 49 PHPs that met the study criteria, only four non-family-based programs listed an integration of AT (Baudinet & Simic, 2021). Non-family-based PHP may be integrative and employ psychotherapy models such as cognitive behavioural therapy (Murphy et al., 2010), dialectical behavioural therapy (Ben-Porath et al., 2009), and acceptance and commitment therapy (Morgan et al., 2021), however, in more complex cases, these models may not fully address the prevalence of trauma and attachment injuries that may be present in the etiology of EDs (Brewerton, 2015). This emphasizes the need for further research into the implementation of creative and trauma-informed experiential approaches to PHPs (Seubert & Virsi, 2018). Therefore, AT may present an integrative and flexible modality to bridge treatment models with attachment-focused and trauma-informed approaches (Malchiodi, 2020) to increase accessibility for adolescents via a ‘non-threatening’ modality (Riley, 1999). Research and development of a trauma-informed intervention program for this population and setting begin to address gaps in the literature by outlining a program structure and rationale for expanding the role of AT on multimodal teams.

## Implications for Art Therapy

AT is a psychotherapeutic intervention that can facilitate the identification and externalization of feelings and behaviours concerning an ED to integrate new insights and

promote more adaptive ways of coping (Ki, 2011). AT may complement or serve as an adjunct treatment to multimodal treatment approaches for AN including family therapy, group therapy, and/or individual therapy. By emphasizing client-centered expression, AT may address gaps within a multimodal team approach by allowing clients agency through the choice of media and means of expressing therapeutic content in treatment (Brooke, 2008). Through creative exploration, integration of the senses, embodiment, and symbolism, clients learn to tolerate feelings of anxiety (Fleming, 1989), challenge their perfectionism (Shaw, 2020), and document change in various biopsychosocial domains of treatment (Morenoff & Sobol, 1989). AT is particularly relevant to the treatment of EDs as the inherent qualities of art-making correspond with symbolic behaviours and symptoms of EDs (Naitove, 1986). For example, art materials can be used in a sensory-based way to encourage reflection on one's relationship with the body, food, and control (Wood, 2000; Levens, 1987; Brooke, 2008; Makin, 1994). As individuals with EDs often rely on verbal defense mechanisms in therapy (Hinz, 2006), the use of art-making may also reduce anxiety and resistance to the therapeutic process as a medium of communication while promoting an active role for clients (Brooke, 2008).

**Statement of Purpose**

This study seeks to explore the role of AT and the gaps this treatment approach may address within multimodal treatments for adolescents with AN in PHP settings. These findings will be used to inform the development of a group AT intervention plan that aligns with existing multimodal treatments using an attachment-focused and trauma-informed approach.

**Personal Relationship and Motivations**

Personal relationships to the topic and motivations for pursuing this project should be identified to situate the researcher and to identify personal biases. Having lived experiences with AN as an adolescent, I have witnessed and experienced the therapeutic potential of group AT for ED treatment in an inpatient multimodal setting. This introduction to AT sparked my interest in the field and in working with populations with EDs in both clinical and community settings.

On a practical level, my practicum experiences working with children and adolescents in an outpatient child psychiatry hospital setting have presented me with several opportunities to implement various multimodal approaches into my AT work with clients. Through collaboration with a multimodal clinical team, I have gained valuable knowledge and interest in the advantages

of integrating creative arts therapy work within clinical settings as an adjunct and complementary treatment for various mental illnesses that affect children and adolescents.

## Significance and Need

### *Practical Implications*

AN is a multifaceted mental health challenge with rising prevalence rates, severe psychosocial burdens, and complex treatments (Hay et al., 2014). The chronic nature of AN involves lengthy and costly treatment plans (Stewart & Williamson, 2004a; van Hoeken & Hoek, 2020; Lester, 2019; Crow & Nyman, 2004) to achieve full remission or attain significant improvements due to the costly physician visits, psychiatric hospitalizations (de Oliveira, 2017; Lester, 2019), chronic unemployment, strains on the family and its resources, and relapse rates between 9-52% (Khalsa et al., 2017). Existing treatments are moderately effective at best, where an average of only approximately 50% will make a full recovery after treatment (Treasure et al., 2020). The complexity of attempting to understand the development and maintenance of AN through biopsychosocial factors reinforces the need for a flexible and multi-faceted approach to its treatment (Matto, 1997; Wonderlich et al., 2007). As such, researchers have indicated a need for research assessing multimodal interventions that incorporate alternate systems of delivery and therapeutic approaches (Chavez & Insel, 2007; Schaffner & Buchanan, 2010). Notably, a recent Canadian study by Couturier and colleagues (2020) identified several gaps for future work such as enhanced research efforts on new adjunctive treatments to address severe ED and complex comorbidities. This includes experiential therapies, such as AT, to complement traditional verbal psychotherapies.

### *Research Implications*

A preliminary literature search yields a lack of peer-reviewed articles and literature investigating specific AT interventions and structures in complementing multimodal treatment. Specifically, existing articles examine the implementation of manualized AT (e.g. Brockmeyer et al., 2021; Lock et al., 2018) as a comparison group with another treatment modality, (e.g. cognitive remediation therapy), however, do not specify what specific interventions are used, how they are implemented, and who implements them. As a result, there is a lack of validity, reliability, and replicability in such studies that do not detail their methods for further implementation (Kapitan, 2018; E. Smallwood, personal communication, October 19, 2023). In other words, although some studies may yield promising results, there is no continuity or

sustainability in proposed AT interventions as there is no way for other clinicians to replicate these interventions without further details.

**Definition of Key Terms**

In this section, the following terms: *trauma, art therapy, multimodal treatment, day hospitalization programs, adolescence, anorexia nervosa,* and *intervention* will be operationalized to ensure comprehension between author and reader.

*Trauma* describes unique individual experiences of an event, set of events, set of circumstances, and/or conditions that an individual experiences as physically or emotionally harmful (Dalenberg et al., 2017; Pearlman & Saakvite, 1995). Trauma may lead to various lasting adverse effects on the individual's emotional, behavioural, physiological, psychological, emotional, and social functioning (Dalenberg et al., 2017). There are many events and conditions considered as trauma (e.g. physical, emotional, sexual abuse; neglect; domestic violence; terrorism; intergenerational trauma; cultural trauma; serious illnesses; separation from caregivers; living in an unstable or unsafe environment; bullying, etc.). What is considered as traumatic by an individual is largely based on and defined by their personal experience and perception of the event(s) (van der Kolk, 2014). One's response to trauma is further complicated by temperament, attachment status, and proximity to the event (Seubert & Virdi, 2018).

*Art therapy (AT)* is defined as the use of art, media, images, and the creative process in facilitating therapeutic self-exploration and understanding. AT facilitates therapeutic means for the client to externalize and reconcile emotional conflicts, foster self-awareness, develop coping skills, increase self-esteem, and work through thoughts and feelings visually that would otherwise be difficult to articulate (*What is Art therapy? — Canadian Art Therapy Association,* n. d.). It is important to distinguish that AT differs from art class or art education as AT focuses on the process of art-making (versus the product) within a therapeutic space facilitated by a trained art therapist. AT can also be described as an action-oriented, experiential, and non-verbal therapy that emphasizes the triangular relationship between the client, artwork, and art therapist.

*Multimodal treatment* for EDs involves a collaborative team of professionals, including psychiatrists, nurses, nutritionists, psychotherapists, and/or social workers working together to provide comprehensive biopsychosocial assessment and integrated treatment. Treatment may include supervised meal support and plans, medication, individual therapy, group therapy, and/or family therapy (Lask & Bryant-Waugh, 2013). Multimodal therapeutic approaches incorporate

various theoretical frameworks (Couturier et al., 2020).

*Partial hospitalization programs (PHPs;* also known as *day hospitalization* or *day programs*) are specialized secondary and tertiary hospital settings for ED treatment. PHPs offer services to medically stable clients who still require intensive treatment and involvement in therapeutic groups (Crone et al., 2023; National Institute for Health and Clinical Excellence, 2017). PHPs offer unique characteristics: clients undergo intensive daily treatment during weekdays and return home at the end of the day to retain their social relations and daily living while allowing the integration and consolidation of progress achieved during the day (Abbate-Daga et al., 2009). PHPs can serve as a step down from inpatient hospitalization and a step up from outpatient care or other community-based or secondary services (Harrison, 2011).

*Adolescence* (12-18 years of age) is a transitional life stage between childhood and adulthood starting with puberty (around 10-12 years of age) and ending with physiological, neurobiological, and psychological maturity, a process that may extend until 25 years of age (American Psychological Association Dictionary of Psychology, n. d.). As hospital programs transition clients over 18 years of age to adult care due to the legal age of majority in most Canadian provinces (Government of Canada, 2024), the definition for adolescence within this paper will be considered as those aged 12-18.

*Anorexia nervosa* (AN), as defined by the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; American Psychological Association, 2013), is an ED characterized by persistent restriction of energy intake, leading to significantly low body weight in the context of an individual's age, sex, developmental trajectory, and physical health. Individuals with AN have an intense fear of gaining weight or becoming fat, along with a distorted body image and an excessive focus on body weight and shape. This disorder often involves behaviours aimed at avoiding weight gain, such as excessive exercise, self-induced vomiting, or the misuse of diet pills or diuretics. AN consists of the restricting subtype (AN-R) and the binge-purge subtype (AN-BP). This paper will only focus on the restricting subtype given the differences in conceptualization and presentations between AN-R and AN-BP (e.g. Individuals with AN-BP commonly demonstrate increased impulsivity, lower self-directedness, and increased reward sensitivity/novel-seeking compared to those with AN-R; Farstad et al., 2016). For the sake of clarity, the term "AN" will be used to denote the AN-R subtype.

*Intervention* is a purposely implemented strategy and approach for change or action taken

by a therapist to address a specific issue, symptom, and/or challenge faced by client (Fraser & Galinsky, 2010, p. 459).

## Chapter 2. Intervention Research Methodology

### Research Questions

The primary research question of this theoretical intervention-based research study is: how can a trauma-informed AT group program be designed to support adolescents with AN within a multidisciplinary PHP context? This research will also address the following subsidiary questions: 1) What might a trauma-informed AT group for AN in a PHP setting look like? and 2) What are the current best practices and barriers to integrating AT within multimodal AN treatment teams in hospital settings?

### Methodology

Intervention research, as described by Fraser and colleagues (2009e), is a "dynamic and creative process encompassing the design, development, and dissemination of interventions" (p. 157). This methodology aligns with the proposed research inquiry as it supports the translation of practice-based research, practical knowledge, and existing theories into intervention development and design that meets the needs of an identified group (adolescents with AN) in a chosen context (PHPs; Fraser & Galinsky, 2010; McBride, 2016; Bradt et al., 2013). Specifically, this focus of research will facilitate the critical analysis and synthesis of ideas to establish links between theory, research, and practice.

When choosing a method to collect data, Blair (2016) suggests understanding the underlying beliefs, strengths, and limitations of the chosen research methodology. Situating myself through a pragmatic and anti-dualistic epistemological lens (Johnson et al., 2007; Wheeler & Murphy, 2016), this methodology allows me to examine practice-based data, peer-reviewed data, and grey literature in prioritizing anti-oppressive approaches to research to construct a multi-faceted knowledge base (Onwuegbuzie et al., 2016). However, it's important to note that this methodology will be applied using a theoretical lens, considering the delimitation of only conducting Steps 1 and 2 of Fraser & Galinsky's (2010) five-step methodology which won't include the implementation or testing of the program. Given the project's scope, this section will exclusively focus on outlining Steps 1 and 2 in greater detail.

### Intervention Research Steps

Rooted in Rothman & Thomas' (1994) six steps of intervention research, Fraser &

Galinsky's (2010) intervention research methodology uses the following five-step model: 1) develop problem and program theories, 2) specify program structures and processes, 3) refine and confirm in efficacy tests, 4) test efficacy in practice settings, and 5) disseminate program findings and materials.

### *Step 1: Develop Problem and Program Theories*

**Problem Theory.** The development of a problem theory (Fulbright-Anderson et al., 1998) forms the foundational stage of building a causal logical model for the basis of the proposed intervention (Fraser et al., 2009c). This stage includes describing the problem of focus in terms of incidence and prevalence. Establishing this groundwork will support the development of a structural model outlining risk and protective factors relating to the problem (e.g., those influencing AN development and maintenance), and mediating factors, or change strategies, that provide information on how and when an intervention may be useful.

**Program Theory.** This phase of program theory development involves identifying which of the risk factors in the problem theory are malleable (i.e. capable of being influenced or could be responsive to intervention) as an entry point for the introduction of the proposed intervention (Fraser et al., 2009b). The identification of malleable mediators must be matched with evidence-based change strategies in developing a proposed intervention.

This stage of program theory development also includes creating a logic model and theory of change through the identification of the intervention level(s), setting(s), agent(s), program inputs, program objectives and activities, program outputs, proximal and distal outcomes, a change model, and benchmarks for success (Fraser et al., 2009b).

Logic models are based on problem theory and are created to specify the intervention process and its core elements. Logic models consider intervention objectives, inputs, and activities, and how these elements culminate in various outcomes (Fraser et al., 2009c).

Theories of change outline the causal chain of events needed for positive intervention outcomes (Fraser et al., 2009c). Throughout the process of developing an intervention, theories of change outline why particular intervention methods are selected, providing a pathway for expected outcomes and justification for program activities and settings.

### *Step 2: Specify Program Structures and Processes*

The central task in Step 2 involves translating theoretical findings, generalizations, and implications from the literature into program prescriptions and materials in the design of the

intervention (Fraser et al., 2009b).

**Formulation of Program Manuals and Materials**. Step 2 is concerned with the formulation of a program that consolidates data and theories gathered from Step 1. In other words, the problem theory, risk factors, protective factors, and malleable mediators are summarized in logic models and theories of change to provide a rationale for the intervention, which is disseminated through program manuals and materials (Fraser et al., 2009d). Practice manuals may vary, from offering suggested activities to providing step-by-step outlines of delivering the intervention.

Considerations for the formulation stage include the identification of systemic and cultural factors affecting the problem theory, who will provide the program, the feasibility of the change strategy, individual and contextual factors, malleable factors, and innovation of the program theory. Intervention program considerations include frequency, duration, structure, rationale, potential adaptations, and barriers to participation. Specific session content considerations include identifying objectives and linking these objectives to mediators (Fraser et al., 2009d).

**Data Collection**

Intervention research aims to collect both qualitative and quantitative data to support the development of the intervention (Fraser & Galinsky, 2010). When considering phenomena that require analysis of complex, multi-person interactive behaviours and social contexts, researchers may be limited to qualitative data to capture such systemic and social processes (Nastasi & Schensul, 2005). As such, I will be collecting both qualitative and quantitative data (where available) for this research (Creswell & Creswell, 2018). Data collection will be synthesized in the form of a literature review to indicate what is known and what is yet to be known using primary sources (Blair, 2016). It will also serve as the foundation for the development of problem and program theories in Step 1 and justify the rationale for the research (Blair, 2016)

Data will be gathered from various search engines and databases including Sophia, Spectrum Repository, Google Scholar, PsycINFO, PubMed, ProQuest, and ScienceDirect, with search terms including *trauma, trauma-informed, attachment, attachment-focused, art therapy, eating disorders, anorexia nervosa, adolescence, youth, multimodal treatment, multidisciplinary team, day hospitalization, trauma-informed, group,* and *therapy.* The literature search will involve the identification and collection of relevant literature in related fields of psychology,

psychiatry, counselling, and medicine as long as they fit the criteria. Guiding parameters for data collection will be divided into an inclusion/exclusion criteria for 1) problem theories and 2) program theories.

**Problem Theories**. The inclusion/exclusion criteria will consist of: 1) full-text manuscripts (excluding abstracts) published in the last 35 years, 2) materials available in English, 3) practice-based and non-practice-based peer-reviewed studies that include children, adolescent, and/or adult participants with an ED, with a focus on applications of psychotherapeutic approaches, and 4) practice-based and non-practiced-based grey literature including theses, dissertations, book chapters, reports, presentations, policy statements, and discussions with professionals in the field relating to AT, AN, and adolescent ED treatment.

**Program Theories**. Due to the lack of practice-based research in AT and EDs, the inclusion/exclusion criteria for the program theories will consist of 1) full-text manuscripts (excluding abstracts) published in the last 35 years, 2) materials available in English, and 3) practice-based literature implementing group AT interventions through a psychodynamic, trauma-informed, attachment-focused, and/or mind-body approach with a variety of populations and concerns, not limited to EDs. A strong focus on ED populations will be emphasized, however, AT studies with other relevant groups will also be discussed. Relationships between the research question and chosen studies that do not focus on ED populations will be outlined in Table 5 in Appendix A for clarity and its implementation in the current study.

Collected data will be organized in researcher-devised literature review summary tables (McBride, 2016). As a delimitation, the literature review summary tables in Appendix A (Tables 1-4) will only identify literature focusing on the use of AT for ED treatment into the following organizational categories, where appropriate: the study design, population of focus, interventions used, goals of the interventions, the therapeutic modality, facilitator(s), and concurrent therapies. Other literature sources will be summarized throughout.

**Data Analysis**

In considering Steps 1 and 2, data analysis is limited to coding and synthesis methods of the literature in informing the intervention development. For this research project, thematic coding (Neuman, 2006) will drive the creation of a thematic (Thomas & Harden, 2008) and narrative synthesis (Popay et al., 2006). This synthesis serves two main purposes: first, providing background for the study, and second, aiding in the development of program and problem

theories, logic models, and theories of change.

Thematic coding is a method of analyzing qualitative and quantitative studies and literature (Neuman, 2006). The steps of thematic coding include both open coding and axial coding with a focus on identifying themes (Neuman, 2006). First, it will involve familiarization with the data and the development of initial codes via open coding to group relevant sections of data to capture preliminary themes. This stage encourages free exploration and the identification of numerous codes without predefined categories (Neuman, 2006). Subsequently, axial coding, considered a "second pass" through the data (Neuman, 2006), will involve reviewing and examining these initial codes to identify categories that might cluster together. This phase aids in linking concepts and themes for consolidation. Themes that emerge from thematic coding will guide a thematic and narrative synthesis of the literature.

Narrative synthesis is a method used in systematic reviews to summarize and integrate findings from multiple sources of qualitative or quantitative data (Popay et al., 2006). Narrative synthesis can support the development of theories surrounding how, why, and for whom interventions work. (Popay et al., 2006). It can also support the exploration of relationships within and between studies while evaluating the robustness of the synthesis. One approach in this process involves the grouping of data based on type, study design, and conclusions (Popay et al., 2006). While thematic synthesis focuses on coding and deriving themes from data, narrative synthesis involves integrating these themes and findings into a cohesive narrative. By combining thematic and narrative synthesis, this process will delineate crucial intervention themes and synthesize practice-based findings essential for their implementation in the program development phase.

**Validity, Reliability, Limitations**

In Steps 1 and 2, conclusions that can be drawn take form through the proposed intervention plan. The intervention plan weaves together conclusions from collected and synthesized data from Steps 1 and 2 regarding problem and program theories while targeting risk and protective factors and malleable mediators. Beyond these, Steps 1 and 2 also reveal insights about the feasibility and suitability of the intervention for the target population and setting, potential barriers, session structure, and ethical considerations. However, without efficacy testing, definitive conclusions about effectiveness, generalizability, and recommendations cannot be made, though they could be considered theoretically.

Most validity and reliability considerations lie in the efficacy testing phases of Steps 3-4 (McBride, 2016); however, one must also consider limitations in the validity and reliability of conducting theoretical intervention research. Specifically, there is a limitation out of one's control in found literature in terms of dominant Western perspectives, experience of the researcher, language accessed, and scope of research. Factors impacting validity and reliability within one's control may be explored through the various perspectives of judging the quality of qualitative research, from applying quantitative terms (internal validity, external validity, reliability, and objectivity) to qualitative research (Creswell, 2013), to considering trustworthiness as an alternative to validity in qualitative studies (Lincoln & Guba, 1985).

Although a systematic review is outside of the scope of this project, a review protocol may be outlined to assess and minimize the risk of bias in the process. A review protocol may specify comprehensive search strategies with clear criteria to select or reject studies (e.g. the inclusion/exclusion criteria), a process for assessing individual study quality, and a standardized method of extracting and synthesizing data (e.g. coding) (Demiris, 2019). Validity, reliability, and replicability will also be addressed by detailing the literature search process, collection, and interpretation, including search strategies and search terms (Kapitan, 2018). Materials included in the Appendices that may increase validity and reliability include the literature review summary tables (McBride, 2016) and details of the intervention plan (Kapitan, 2018; E. Smallwood, personal communication, October 19, 2023).

Given the considerable lack of empirical, evidence-based research, and outcome-focused studies in the field of AT and AT with EDs (Bucharova et al., 2020), one's ontological and epistemological assumptions and paradigms (Creswell & Creswell, 2018) must be considered when interpreting and integrating these findings into clinical work. While AT is used in the clinical treatment of EDs, much of the published work in this field consists of case studies (Frisch et al., 2006) versus objective randomized-controlled trials. This is important to keep in mind as interpretivism ontology, such as those in case studies and other qualitative research methods, is more prone to the influence of assumptions, feelings, and emotions of the researcher, in combination with the mechanisms and processes involved in the studies (Betts & Deaver, 2019). Clinician-lived experiences working with individuals with AN as documented in case studies may be valuable, yet lead to publication biases (E. Smallwood, personal communication, December 21, 2023). Whether this is an advantage, disadvantage, or both within the field of AT

may be argued further, however, it is not within the scope of this paper.

## Ethical Considerations

For Step 1, ethical considerations include ensuring transparent communication of problem and program theories informed by diverse perspectives from a culturally humble lens. Sensitivity towards diverse populations and avoiding language or assumptions that may perpetuate biases and stereotypes will be crucial in this step. In addition, the problem and program theories should be relevant and align with population needs; the proposed intervention plan should be genuine and cannot be tokenistic. In Step 2, it will be crucial to promote equity in access while minimizing risks associated with the proposed intervention plan when planning and considering the intervention plan, levels, group identification, and other details.

### *Position of the Researcher*

As this research is solely carried out by me, it will be important to situate myself and identify social locators to ensure research reflexivity and identify potential biases (Kapitan, 2018). Situating myself as a fifth and second generation Chinese-Canadian[1], English-speaking, cisgender, straight female having grown up and currently living in an urban Canadian city, I acknowledge my privilege in pursuing post-secondary education and graduate studies and the dominance of Western theoretical paradigms that inform my clinical and research work. These social locators represent a position of power, privilege, and potential diversion from BIPOC experiences, which should be considered through an intersectional lens in considering self-reflexivity and reader reflexivity in engaging with this work.

Having had lived experiences with AN as an adolescent myself, working with this clientele may present many challenges and countertransference reactions including but not limited to overly identifying with the clients' experiences, struggling to maintain objectivity due to personal belief that certain treatment models or interventions are better or worse than others, taking on the emotional stress associated with working with such clients, and spending the majority of the working day speaking about ED symptoms (which may in turn trigger personal reactions and experiences; Arzt, 2020). Alternatively, lived experiences may also serve as a valuable source of information to inform the client side of treatment.

Considering my role as an AT intern and first-time graduate-level researcher who is limited to literature written in English, I will be limitexd in my competence, training, and

[1] Fifth generation on my father's side and second generation on my mother's side.

sources, which may lead to unique challenges and a predominantly Western lens in considering the sensitivities of this population. Additionally, therapists working with populations with EDs often acquire additional special training as there are many considerations and risks when working with this population. Considering my role as a student without experience working with this population and without additional training, my insufficient expertise will be a limitation in interpreting and implementing these findings, necessitating further consideration and consultations with creative art therapists who do have a specialty in this domain.

## Chapter 3. Literature Review: Problem Theories

Drawing from multidisciplinary sources including practice-based research and grey literature, this integrative literature review aims to examine the existing body of knowledge at the intersection of trauma-informed and attachment-focused AT approaches for adolescents with AN. The primary objective of this review will be to provide a conceptual framework to inform problem theories. First, the background and context of adolescent development and AN will be discussed, followed by an elaboration on PHP treatment. Next, a preliminary literature search will synthesize trauma-informed approaches, including relevant frameworks addressing attachment and the etiology of EDs. Finally, a preliminary literature search will synthesize the therapeutic functions and potentials of AT for ED populations through psychodynamic and trauma-informed frameworks.

### Adolescent Development

The period of adolescence between the ages of 12-18 presents great challenges and risks to identity development including: a changing physical body and increasing sexual awareness, a developing brain, hormonal imbalances, increasing educational expectations, and a need for independence combined with familial and societal stressors (Webb, 2019). While some theorists conceptualized adolescence as distinct stages (e.g. Blos, 1966), contemporary theorists commonly view adolescence as a forward motion, consisting of a process of evolving and becoming (Haen & Webb, 2019). As such, effective clinical work with adolescents must be informed by acceptance and support of developmental processes, rather than viewing them as obstacles to more mature engagement (Haen & Weil, 2010).

#### *Identity and Social Development*

Erikson's (1959) psychosocial stages emphasize identity development as the central focus of adolescence. Specifically, Blos (1966) adds that the major task of adolescence is to

individuate and separate from the family of origin. The task of separation and individuation consists of breaking away from parental control in order to establish an individual identity, however, this can be a frightening and difficult task (Mahler, 1972; Moon, 2012; Blos, 1966). Blos' (1966) individuation-separation theory suggests that adolescents turn to peers while rebelling against or distancing themselves from parents to cope with these challenges (Gilmore & Meersand, 2014). Separation-individuation conflicts during adolescence typically concern the adolescent's privacy and growing autonomy (Phinney et al., 2005), driven by a desire to redefine oneself outside the family of origin. Family closeness and attachment remain a major factor in predicting adolescents' adjustment, serving as protective mechanisms against engaging in maladaptive behaviours, which foster both positive and negative experiences (Adams, 2005).

### *Neurodevelopment and Cognitive Development*

Brain changes during adolescence are among the most significant and important neurodevelopmental changes in the human lifespan (Steinberg, 2010; Siegel, 2014). With the remodeling of the brain's dopaminergic systems, adolescents display increased risk-taking behaviours, reward and novelty-seeking, emotional intensity, capacity for social engagement, self-regulation, creative exploration, judgement, and long-term planning (Siegel, 2014; Steinberg, 2008). As adolescent brains are still developing, this stage marks an important and crucial time for mental health intervention and early prevention (Adams, 2005).

Cognitive changes during adolescence include the onset of the formal operational stage, in which adolescents move from an emphasis on the more concrete and here-and-now thinking to abstract thought and hypothetical reasoning (Inhelder & Piaget, 1958). In this stage, adolescents begin thinking about the future by planning and exploring causation and thinking about their thoughts, becoming more aware of their cognitive processes (Adams, 2005). With the onset of formal operational thought, adolescents begin separating their thoughts from those of others, beginning to account for other people's thinking through egocentrism, confusing between others' thinking and one's own (Adams, 2005). Elkind (1985) theorizes that egocentrism is demonstrated in adolescents' preoccupation and self-consciousness with one's physical attractiveness, appearance, and body image.

### *Emotional Development*

By the teenage years, most adolescents have developed a large body of emotional knowledge and competence and begin developing the ability to infer others' emotions (Saarni et

al., 2006). A central feature in adolescent emotional development is the capacity for understanding emotions in relation to interpersonal systems and understanding the causes and effects of emotions (Fischer et al., 1990). The emotional period of adolescence has long been associated with storms and stress (Hall, 1904). Compared to their parental counterparts, adolescents experience greater extremes of emotions, with wider ranges between the lows and highs of daily emotions (Larson & Brown, 2007). It has been suggested that adolescents experience their emotions as intensely personal, as making up the core of who they are (Haviland et al., 1994). As rapid fluctuations between low and high emotions become characteristics of adolescence, teens must acquire the ability to a) regulate intense emotions, b) learn self-soothing techniques, c) increase awareness of their emotions without being overwhelmed by them, d) understand the consequences of their emotions for others, e) distinguish feelings from facts to avoid biased emotion-driven behaviour, f) manage emotional arousal regarding empathy and sympathy, and g) manage feelings of love, hate, or indifference in relationships with others (Adams, 2005). Successful emotional regulation is vital to future well-being in adulthood in personal, parental, and occupational domains (Härtel et al., 2005).

***Art Therapy with Adolescents***

In her extensive work with adolescents, Riley (2001) postulates that AT may be particularly suitable for adolescents as it is developmentally appropriate: adolescents are drawn to creativity, creating images, symbols, metaphors, and graphic depictions and therefore may be more attracted to using art as communication over verbal questioning (Malmquist, 1978). The quality of AT most appealing to the adolescent, however, is that art is a "natural language of adolescents" (Moon, 1998, p. 175), is non-threatening (Riley, 1999), and possesses meta-verbal qualities. Adolescents feel they have control over their art-making and communication, creating as little or as much as they want in session (Riley, 2001). AT provides an outlet for adolescent self-expression through mastery of media (Linesch, 1988), structured processes (Vick, 1999), and independent expression (Higenbottam, 2004). In considering these factors, Riley (2001) considers the greater chances of adolescents remaining in therapy due to AT's less threatening nature compared to traditional talk therapies, with a recent study supporting the evidence for adolescents' positive feedback for AT compared to verbal psychotherapy groups (Versitano et al., 2023).

Conversely, art-making throughout childhood may decline or stop as children due to the

belief that they lack talent, or that art is not a serious occupation (Appleton, 2001). By adolescence, very few individuals will continue to pursue art regularly. As a result, the art therapist's engagement with an adolescent through art-making may result in fear and even resistance (Landis & Williams, 2019). With this in mind, art-making may help break through resistance and fear and assist in the separation/individuation stage of adolescence by giving them control over their expressions and utilizing personal metaphors and symbols to represent the self (Riley, 1994).

AT has also been identified as a useful treatment option for complex mental illness, particularly for young people who have difficulty expressing their emotions safely or verbally (Gantt & Tinnin, 2009). The inherent qualities of AT provide freedom for self-expression and self-exploration to empower youth to develop healthier internal coping mechanisms, or replace maladaptive ones, such as disordered eating. As adolescents explore and master different art media and approaches, they are provided with opportunities to move towards independence and a secure identity (Riley, 2001), while improvements in social relationships, school performance, and self-esteem are also observed (Boston, 2013).

**Group Therapy.** The group therapy format may be offered as a solution to counteract the common negative attitudes of this age group surrounding individual and family therapy (Riley, 1999). For adolescents, few things are as important and influential as how they are regarded by their peers (Moon, 2012). The group setting for adolescents is particularly useful, taking advantage of the developmental needs of adolescents that consist of reliance on peers in replacement of parental influence and structure (Riley, 1999). Group AT aids in creating a sense of ritual, providing psychological safety, and promoting interpersonal and emotional risk-taking, while fostering a sense of personal and communal empowerment (Moon, 2012). On the other hand, built-in relationships and tensions are common in adolescent AT groups (e.g. sexual attractions, rivalries, comparison, competition for the leader's attention and approval, domination, etc.; Moon, 2012). These dynamics present opportunities for group members to repair past experiences by transforming maladaptive behaviours and reactions into adaptive responses via art-making (Moon, 2012).

**Resistance**. Historical views of therapeutic resistance have been a judgmental stance (Altman et al., 2010), however, recent theorists have broadened this perspective to view resistance as an indication of progress or valuable information in treatment (Landis & Williams,

2019). When revisiting developmental changes during adolescence, Emunah (2005) writes that due to the chaotic nature of this maturational phase, "adolescent resistance to treatment often can be confused with age-appropriate and healthy rebelliousness" (p. 109). Resistance is often a psychological protection developed by a client to preserve an inner sense of ego identity (Moustakas, 1995) and to present the self in a manner that denies the existence, consequences, and inner emotional experiences of challenging behaviours (Moon, 2012).

## Anorexia Nervosa in Adolescents

### *Incidence*

Very few studies examine the incidence in the general population and within the specific age group of adolescents. Such studies are often dated and may not represent the current picture (e.g. Hoek, 2006). Two recent studies estimate incidence rates of AN in adolescents, however, within a defined WEIRD (Western, Educated, Industrial, Rich, Democratic) population. A study by Silén and colleagues (2020) studied Finnish twins between the ages of 10 and 20 years, estimating a 10-year incidence of AN as 580 per 100,000 person-years among females and 30 per 100,000 person-years among males. Another study, done in the UK and Ireland surveyed young people aged 8 to 17 and estimated an 8-month incidence rate of 13.68 per 100,000 persons, with rates of 25.66 for young women and 2.28 for young men (Petkova et al., 2019). In the first cross-country study in North America to describe the incidence of AN among children, Pinhas and colleagues (2011) examined cases identified through the Canadian Pediatric Surveillance system to identify an incidence rate of early-onset AN as 2.6 per 100,000 person-years in children aged 5-12. While some studies suggest rates of AN have been fairly stable over time (Hoek, 2006; Smink et al., 2016), others indicate that the incidence of AN has been increasing (Martínez-González et al., 2020; Silén et al., 2020).

### *Prevalence*

Lifetime prevalence estimates for AN are around 0.8% to 6.3% for women and 0.1% to 0.3% for men (Qian et al., 2022; Silén et al., 2020; Silén & Keski-Rahkonen, 2022). Specifically, for AN in female children and adolescents, the prevalence estimate is 0.3-2.0% (Smink et al., 2014; Stice et al., 2013). Little information is available regarding adolescent males, but some studies estimate the prevalence of any ED ranging from 1.2-2.9% (Mitchison et al., 2020; Smink et al., 2014). These findings must be considered within the context of updated and broader DSM-5 diagnostic criteria (e.g. the removal of amenorrhea and a broader definition of "low body

weight"; American Psychological Association, 2013), improved recognition, and evolving understanding of EDs over time (Martínez-González et al., 2020).

### *Impacts of the COVID-19 Pandemic*

On a national scale, data from six Canadian pediatric care facilities revealed a 60% rise in EDs from pre-COVID-19 levels (Agostino et al., 2021), addressing the need for continued research and treatment (Galmiche et al., 2019). In fact, in a recent study of the impact of COVID-19 on EDs among adolescents in Ontario, Canada, Toulany and colleagues (2023) found that emergency department visits and hospitalizations for EDs jumped by 121% above expected levels for adolescents aged 10 to 17 years, with 48.2% of those hospitalizations attributed to AN diagnoses. Additionally, a recent Canadian study by Spettigue and colleagues (2021) found that 40% of newly diagnosed clients attributed the pandemic as a trigger for their ED.

### *Age of Onset*

Many large studies have found the worldwide peak age of onset for AN to be during adolescence and emerging adulthood (i.e., up to age ~25; Favaro et al., 2009; Halmi et al., 1979; Lucas et al., 1991; Micali et al., 2013; Solmi et al., 2021; Steinhausen & Jensen, 2015), placing the peak age of onset between 14-18 years, specifically 15 years for females (Petkova et al., 2019; Silén et al., 2020; Smink et al. 2016). In a study surveying 250 adolescent and young adult outpatients with AN, it was found that those with early age onset (under 16 years) demonstrated higher body dissatisfaction, maturity fear, impulsivity and asceticism than the intermediate onset (17-19 years) and late-onset (over 20 years of age) groups (Abbate-Daga et al., 2007). In addition, researchers found that later age of onset of AN has been associated with poorer treatment outcomes (Abbate-Daga et al., 2007), indicating a need for further research into risk factors, the development of prevention programs, and early intervention with adolescents to moderate treatment outcomes (Allen et al., 2022).

### *Health Challenges*

Developing an ED during the critical adolescent phase of brain and body development can lead to long-term consequences for health, brain structure and function, and life trajectories (King et al., 2018). When an adolescent develops AN, wide impacts and effects are experienced on an individual level (distress, comorbid mental disorders, health-related quality of life, interpersonal relationships) and a broader level in the form of detrimental social and economic outcomes (career and academic opportunities, co-occurring medical problems, high mortality;

Jenkins et al., 2011; Hoek, 2006). Medical complications of AN usually result from starvation, with cardiac problems as the most common cause of sudden death in this population (Mehler et al., 2022). Other common health concerns arising from AN include medical complications with the cardiovascular, endocrine, skeletal, gastrointestinal, and central nervous systems (Herzog et al, 2004).

**Mortality and Morbidity.** EDs are recognized as an important cause of morbidity and mortality in adolescents, with the highest rates occurring in those with AN (Arcelus et al., 2011). A meta-analysis of 36 studies between 1966 and 2010 found a weighted mortality rate of 5.10 deaths per 1000 person-years, of which 1.3 AN deaths resulted from suicide (Arcelus et al., 2011). Strong predictors of mortality include a combination of comorbid disorders and challenges such as affective disorders, suicidal behaviour, self-harm, alcohol abuse, and a history of hospitalization for mental health challenges (Himmerich et al., 2019).

## Partial Hospitalization Programs (PHPs) for Anorexia Nervosa

As described in the "Definition of Key Terms", PHP is a form of treatment for EDs situated between intensive inpatient hospitalization and less intensive outpatient care or other community-based resources (Harrison, 2011). PHPs have been chosen as an area of focus for their innovative clinical care program to maximize efficiency, costs, and flow to serve more clients while ensuring that clients remain connected to their families, school, and social lives (*CHEO Opens First Pediatric Eating Disorders Partial Hospitalization Program in Canada*, 2023; M. Harrison, personal communication, January 19, 2024).

### *Treatment Needs*

Treatment for AN typically includes individual, family, and/or group psychotherapy; medical care and monitoring; supervised meal support and plans; nutritional counselling, psychopharmacology; or a combination of these approaches (Lask & Bryant-Waugh, 2013), with typical treatment goals including restoring adequate nutrition and healthy weight, reducing disordered eating behaviours (e.g. excessive exercise, bingeing, restricting, etc), and addressing the root causes of the disorder (National Institute for Health and Care Excellence, 2017). As adolescents with AN differ widely in psychological, social, behavioural, and biological functioning, the National Institute for Health and Care Excellence (2017) recommends that treatment and support for AN should include multidisciplinary approaches and should be coordinated between services to maximize recovery and improve quality of life. When

integrated, multidisciplinary approaches work to not only restore an individual's weight but to also reduce pathologized eating behaviours, distortions of shape and weight, and to manage mental and physical comorbidities (Hay et al., 2015).

### *Structure*

PHPs are recommended for clients whose symptoms are too severe to be treated by an outpatient team but do not require inpatient hospitalization for medication stabilization or complete containment of behaviours (Brown et al., 2017). At the PHP level of care, most programs provide patients with 6-10 hours per day of treatment, including individual therapy, group therapy, family therapy, supervised meals, medication management, and other therapeutic programming including creative arts therapies (Ben-Porath et al., 2010). The PHP model borrows from the benefits of both inpatient and outpatient care: supervision during and after meals helps facilitate weight restoration, resumption of normal eating patterns, and interruption of compensatory behaviours, while nights and weekends spent away from the PHP allow clients to practice using their skills in a more natural and often challenging environment (Zipfel et al., 2002).

### *The Multidisciplinary Team*

As clients with EDs differ widely in their psychological, social, behavioural, and biological functioning, best practices at treatment centers include a variety of integrated and multidisciplinary programs (Couturier et al., 2020). The multidisciplinary team involves a collaborative team of professionals, including psychiatrists, nurses, nutritionists, psychotherapists, and/or social workers working together to provide comprehensive biopsychosocial assessment, integrated treatment, and monitoring of clients' medical, nutritional, and psychological status in treatment (Hunter, 2016).

**Group Therapy**. Group therapy provides comprehensive exposure to many therapeutic factors that facilitate ED recovery. Specifically, the purpose of group therapy is to provide an opportunity for clients to overcome their sense of isolation by discussing shared experiences of common fears, anxieties, and difficulties in treatment with other clients (Stewart & Williamson, 2004b; Diamond-Raab & Orrell-Valente, 2002). Groups for ED recovery are generally classified as skills-based, training, psychoeducational, support-based, psychotherapy, or a combination of these (Stewart & Williamson, 2004b).

**Art Therapy**. There has been an AT presence in PHP settings, but it has not been studied

thoroughly. In Baudinet & Simic's (2021) scoping review of PHPs treating adolescents, only four studies (Schaffner & Buchanan; 2010; Fewell et al., 2017; Huryk et al., 2021; Ngo & Isserlin, 2014) listed integration of AT. Such integration is not detailed in terms of the frame, structure, interventions, goals, or facilitator.

## The Role of Trauma in the Etiology of Anorexia Nervosa

AN has been considered from various perspectives including individual (e.g. biological, personality, trauma), relational and familial (e.g. enmeshment, triangulation, neglect), and societal (e.g. gender and cultural expectations). Trauma-informed and attachment-focused theories offer a framework for understanding the development and maintenance of AN.

### *Complex Trauma*

Complex trauma is a term referring to the exposure to multiple or prolonged traumatic events, typically starting in childhood and often involving adverse interpersonal experiences, such as abuse, neglect, or chronic adversity (Cook et al., 2005). It has been argued that complex trauma, extending from childhood through adolescence and into adulthood, can have more pervasive and enduring effects on individual development, attachment patterns, personality, cognition, behavioural control, self-concept, affect regulation, and mental health compared to single-event trauma (van der Kolk et al., 2005).

### *Attachment and Relational Trauma*

Early caregiving relationships provide a foundation in which children develop the earliest psychological representations of self, others, and self in relation to others (Bowlby, 1969). These internal working models form the basis of a child's development throughout the lifespan (Cook et al., 2005). Attachment or relational trauma, described by Schore (2013) as the "quintessential expression of complex trauma" (p. 3), is related to disruptions or disturbances in the formation of secure attachments during crucial developmental periods, such as early childhood (Cook et al., 2005). Attachment trauma can occur when a primary attachment figure is neglectful, an overt abuser, protects an abuser, scapegoats a victim, or gaslights a victim. It can also occur when attachment figures fail to intervene, defend, collude passively or actively, or dismiss and silence a child or adolescent who speaks up (Power, 2023). Returning to the definition of trauma as an event or a condition an individual perceives as threatening and distressing, attachment trauma could also include disrupted attachment bonding, attachment insecurity and disorganization, traumatic loss of a caregiver, parental separation, familial separation, enmeshment, impaired

boundaries, and excessive control (D'Andrea et al., 2012). As such traumatic experiences are often prolonged and ongoing (Cook et al., 2005) the term "attachment & relational trauma" will also encompass the term "complex trauma."

Attachment and relational trauma may severely hinder an individual's capacity to handle stress, regulate emotions without external assistance (e.g. adaptive or maladaptive coping mechanisms such as disordered eating; Schore, 1997; Cooke et al., 2005), and seek help from others in times of need due to an inability to trust and lean on others (van der Kolk, 2014; Teicher & Samson, 2013; Cook et al., 2005). For example, a child's ability to recover from adverse experiences is deeply influenced by the quality of the child's attachments and by the caregiver's ability to respond (Lieberman, 2004). In other words, secure attachment can promote a child's resilience throughout the lifespan (Kravits, 2008).

Traumatic events disrupting the establishment of trust, reciprocity, and healthy boundaries between an attachment figure and a child may permanently alter a child's ability to trust others and themselves. With this in mind, one must note that in cases of attachment and relational trauma, children and adolescents often find it challenging to leave such situations, fearing abandonment, rejection, and neglect, which can even jeopardize their physical well-being (Power, 2023).

**Child Neglect and Enmeshment**. Psychiatrist Krueger (1989) theorizes in the case of child neglect and enmeshment, boundary confusions often occur. For instance, if a mother does not respond to a child's natural feeding schedule or cries for hunger and only feeds when the mother herself is hungry, the child may become reliant on the mother's hunger cues rather than trusting their own bodily signals. This confusion in body cues for hunger and fullness may cause disturbances and weaknesses in the child's developing body image. Moreover, the caregiver's attuned or misattuned feeding style can set the stage for the child's internal working models about whether they are deserving or unworthy of loving care (Finlay, 2018).

**Family Dynamics.** Family dynamics also play a significant contribution to the etiology of AN. According to Minuchin and colleagues (1978), families characterized by an individual with an ED tend to exhibit common characteristics and environmental factors, such as overinvolvement, overprotectiveness, overcontrol, rigidity, lack of conflict resolution, and boundary issues. These dynamics often weaken individual autonomy and boundaries within the family, making it difficult for family members to develop their own identities. Consequently,

children raised in families with high enmeshment may adopt their ED as their identity as they are unable to develop an autonomous self (Evans & Street, 1995; Minuchin et al., 1978). Minuchin and colleagues (1978) also point out that these rigid, rejecting, and chaotic patterns of family functioning can be traumatic for children.

Bruch (1973, 1978) further emphasizes a psychodynamic conceptualization of family dynamics, arguing that a family environment characterized by overprotectiveness and intrusiveness results in few opportunities for self-expression, leading to the development of a compliant "false self" as a defense. Self-starvation is further understood as a "defense against the feeling of not having a core personality of their own, of being powerless and ineffective" (Bruch, 1982, p. 1532). Through this framework, AN has been characterized as a form of protection to gain control over aspects of their lives that seem uncontrollable, and an outlet for communication in achieving personal autonomy and sense of self (Bruch, 1973; Myers & Klinger, 2008).

**Insecure Attachment.** Insecure attachment, according to Cicchetti and colleagues (1993), not only risks impairing individual functioning but can also profoundly disrupt an individual's psychological development during sensitive life periods. Adolescence, with its focus on independence and separation from parents, becomes a particularly delicate period for the emergence of attachment dynamics and trauma. Early writers (Bruch, 1973; Swift & Stern, 1982) describe the psychodynamic role of attachment trauma in the development of AN. These theories highlight an individual's struggle to achieve autonomy from intrusive and controlling parental/caregiving figures, resulting in an over socialized and highly compliant false self. The seminal work of psychiatrist Hilda Bruch (1973) highlights that the pursuit of thinness can be conceptualized as an interpersonal defense against the demands of adolescence aimed at separating themselves from an intrusive parent. Furthermore, experiences of an insecure or disorganized attachment relationship can also contribute to the development of a negative self-image, fewer strategies in dealing with emotional stress, and a decreased likelihood of leaning on others for support (Zaccagnino et al., 2017). Recent research (Ward et al., 2011; Budia et al., 2022) and reviews (Ward et al., 2000; Tasca, 2019) have also corroborated a positive link between insecure attachment, behavioural inhibition, and AN.

**Treatment Needs.** In a recent research update on attachment and EDs, Tasca (2019) underscores the absence of a developmental perspective in understanding the development and maintenance of ED symptoms. As a result, many practitioners and researchers have turned to

attachment theories to fill the gaps in the conceptualization and treatment of EDs to inform treatment planning (Tasca, 2019). Various studies have considered the impact of attachment insecurity on ED symptoms, with hyper-activation of emotions mediating the relationship between attachment anxiety and ED symptoms (Tasca et al., 2009) and alexithymia mediating the relationship between insecure attachment and body dissatisfaction (Keating et al., 2013). These studies suggest that maladaptive affect regulation as a result of attachment insecurity may play a crucial role in the development, expression, and maintenance of symptoms and cognitions related to EDs (Tasca, 2019). This emphasizes the need for attachment-focused treatment emphasizing affect regulation and emotional experience. Tasca (2019) conceptualizes the following focus of treatment for attachment anxiety and attachment avoidance: reducing fears of abandonment/loss, effectively modulating emotions, developing a coherent narrative of self and attachment relationships, reducing defenses against emotions, and increasing emotional connection to others (p. 62).

**Trauma-Informed Care**

Trauma-informed care describes an approach to providing care and support that acknowledges and responds to the widespread impact of trauma on individuals and families (Steele & Malchiodi, 2012). Trauma-informed care should be distinguished from trauma-focused work as the latter focuses on the treatment of specific trauma, while trauma-informed care operates from an awareness standpoint of how trauma impacts all aspects of life (Malchodi, 2020; Schnurr, 2017).

Trauma-informed practice can be viewed as a strengths-based therapeutic framework guided by the following principles: 1) trauma is part of many disorders and challenges; 2) trauma is not only a psychological experience, but a mind-body experience; 3) symptoms and trauma reactions are reframed as adaptive coping strategies rather than pathology; 4) the individual's interpersonal, cultural, social, political, and environmental backgrounds make up their trauma-related responses and as a result, the family, group and/or community is empowered to collaborate in therapy; and 4) the individual, family, group, or community affected by trauma are not survivors, but also "thrivers" (Malchiodi, 2020, p. 40-42).

Herman (1992) conceptualizes trauma-informed practice as a stage-based approach consisting of three stages outlined below. It is important to acknowledge that Herman's framework is not necessarily linear as individuals will move in and out of stages throughout

treatment (Malchiodi, 2020).

***Stage 1: Safety and Stabilization and Overcoming Dysregulation***

This initial stage focuses on establishing safety and promoting stabilization through the facilitation of a secure and safe environment with adequate social support to promote self-regulation. Psychoeducation is also a crucial part of this stage to support individuals in making sense of the effects of trauma and how they may affect bodily sensations, intrusive emotions, and distorted cognitive patterns (Herman, 1992)

***Stage 2: Remembrance and Mourning***

After establishing a secure base for safety, stabilization, and self-regulation, Herman (1992) emphasizes the importance of recalling and sharing traumatic experiences. The rationale for this is to overcome the fear of traumatic experiences and to initiate the process of integration.

***Stage 3: Reconnection and Integration***

The final stage emphasizes the individual's meaning-making, visions for the future, and reinvention of the self. Herman (1992) describes it as a time for re-engaging with one's community, dreams, and aspirations. At this stage, trauma experiences are integrated and no longer define the individual's life and narrative.

***Trauma-Informed Art Therapy***

Trauma-informed AT aims to repair and integrate trauma by reconnecting implicit and explicit trauma experiences, reducing arousal, regulating emotions, processing sensory information, and promoting secure attachment (Malchiodi, 2020; Hass-Cohen, 2016; Hass-Cohen et al., 2014). Trauma-informed approaches to AT are used to assist an individual's capacity to self-regulate and moderate one's affective and bodily reactions to trauma experiences, setting the stage for trauma integration and recovery (Malchiodi, 2021). Including an art component to trauma-informed care adds an experiential dimension in which adolescents may project distress or challenges while externalizing inner conflicts through a process of self-validation.

**Modern Attachment Theories and Affect Regulation**. Schore & Schore's (2008) modern affect regulation theories bridge the importance of early attachment experiences with neurobiological underpinnings, providing an avenue for AT as an adjunct treatment to current trauma-informed approaches. This framework offers an understanding of the importance of non-verbal mirroring and attunement in shaping neural circuitry and laying the groundwork for

secure attachment. Moreover, the concept of earned secure attachment emphasizes that, through responsive attunement in caregiving or therapeutic experiences, individuals can actively shape their neural pathways to foster resilience, emotional well-being, and healthy attachment that may have been lacking in early life (Schore & Schore, 2008). Earned secure attachment within a therapeutic relationship may manifest through a functional internal change and the ability for an individual to talk about distressing events and relationships to develop a deeper capacity for trust in relational contexts (Findlay et al., 2008). Similarly, Howe (2006) suggests that therapists can make up for deficits in affect regulation by modelling a positive interaction that may be gradually internalized.

Central to attachment dynamics is the implicit and relational process of regulation (Schore, 2011, p. 79). When art is created in the presence of an art therapist, it can facilitate a healing transition from dysregulation to co-regulation and self-regulation through non-verbal right-brain-to-right-brain interaction and attunement (Schore, 2011). Perry (2008) underscores the value of sensory-based approaches in attachment-informed therapy to enhance secure attachment, affiliation with others, empathy, and self-regulation. AT directly engages multiple sensory-based experiences through visual, kinesthetic, tactile, olfactory, and auditory means (Malchiodi, 2014). Furthermore, Bannister (2003) proposes that creative arts therapies are similar to "the naturally occurring interactions between children and their caregivers" due to their use of the body and non-verbal communication (p. 41).

Secure attachment, as defined by Siegel (2003), consists of collaboration, reflective dialogue, repair, coherent narratives, and emotional communication. Attachment-focused therapeutic work strives to recreate a secure base and corrective secure attachment experiences for a client, cultivating a trusting and supportive relationship through psychotherapeutic interventions and alliance building (Salcuni, 2015). This corrective emotional experience begins with the holding environment established by the therapists for the client (Winnicott, 1971). Within AT, the artwork serves multiple roles, functioning as a mediator, a container for the holding environment, and a third client in the client-therapist relationship. This reinforces the collaborative nature of developing the holding environment in AT (Dalley et al., 2013; Armstrong, 2013).

**The Expressive Therapies Continuum (ETC).** The Expressive Therapies Continuum (ETC; Hinz, 2020; Lusebrink & Hinz, 2022) is an interdisciplinary model that links

neurodevelopmental theories and AT through four levels of art-making that correspond with left and right hemisphere functions: 1) Kinesthetic/Sensory, 2) Perceptual/Affective, 3) Cognitive/Symbolic, and 4) Creative. Guidance from the ETC framework is used to support creative arts therapeutic processes through individualized creative processes and integrated functioning. In considering neurodevelopment and AT, Malchodi (2014) highlights AT interventions touching on each level of the ETC, including Kinesthetic/Sensory (sensory use of art materials, textural and tactile elements, self-soothing arts experiences, rituals, physically oriented activities, drawing on large paper to music), Perceptual/Affective (masks and puppets for projection and relational play, arts and crafts for creative expression and skills, group art therapy), and Cognitive/Symbolic (teamwork in group art therapy, problem-solving skills, art for skill enhancement and self-esteem to promote self-regulation (p. 11).

The ETC is tied to trauma-informed and attachment-focused AT work in many ways. For instance, art-making on the kinesthetic and sensory level of the ETC engages the brainstem, which is crucial for attunement and attachment (Lusebrink & Hinz, 2022; Malchiodi & Crenshaw, 2014). AT is also useful in helping individuals communicate memories and stories relating to early attachment experiences that may not be readily available verbally (Hass-Cohen & Carr, 2008). Working non-verbally on a sensory and kinesthetic level (Hinz, 2020) in art-making may help a client unearth and tolerate these memories (Rothschild, 2000). Moreover, the non-verbal nature of art-making contained by the art therapist may be a corrective experience in and of itself for some individuals (Malchiodi, 2014).

**Art Therapy Relational Neuroscience Model (ATR-N)**. The art therapy relational neuroscience model (ATR-N; Hass-Cohen & Findlay, 2015) integrates relational neuroscience and interpersonal neurobiology with AT, focusing on physiological processes during art-making along with the triangular relationship between the art therapist, client, and the art-making process. Specifically, this model suggests that engaging in sensory art-making experiences in the presence of an art therapist can foster the development of an attuned, mindful, compassionate, and integrated state of mind.

***Bodymind Model.*** The Bodymind model (Czamanski-Cohen & Weihs, 2016) is a framework grounded in the perspective of mind and body existing as a unified system. Informed by the ETC (Hinz, 2020; Lusebrink & Hinz, 2022), ATR-N (Hass-Cohen & Findlay, 2015), and theories of neurodevelopment, relational neuroscience, and interpersonal neurobiology, the

Bodymind model outlines how AT may activate body and mind processes for clients through the reorganization, growth, and reintegration of the self. This model highlights four major therapeutic processes: 1) the triangular relationship between the art therapist, the art process, and the art product, 2) self-engagement with the soothing and nurturing quality of art materials in a safe and supportive space, 3) embodied self-expression through the transition from implicit to explicit processing, and 4) the exploration of meta-cognitive processes. The triangular relationship in AT is pertinent to trauma-informed and attachment-focused clinical work, facilitating a secure attachment resembling primary attachment relationships (Czamanski-Cohen & Weihs, 2016). Specifically, clients are welcomed by a supportive individual (the art therapist) who provides a consistent and safe environment for personal exploration and expression. As a client explores the art therapy environment, the art therapist observes and makes themselves available to the needs of the client, similar to the good-enough mother providing a secure base for their child to return to as they go out to explore the world (Bowlby, 1988). The engagement with art materials combined with the activation of the senses on a sensory and tactile level results in the engagement of the body and mind aspects of the self. With such activation in the context of an attachment figure and safe space, clients have the opportunity to repair attachment issues that may arise in their relationship with the therapist, art materials, art-making process, and the art product.

**Group Art Therapy.** In considering arts-based groups, Moon (2016) outlines the importance of the art studio setting, range of art materials and equipment, rituals of beginning and ending sessions, group rules, and the structure of the session in providing stability, consistency, and psychological safety for group members. In particular, the use of rituals in preparing, welcoming, art-making, sharing, and closing helps to establish a "predictable rhythm" that group members can rely on and establishes group safety (Moon, 2016, p. 53). Rituals help reinforce social cohesion, encourage safety and predictability, create boundaries of the group container, and help to form a unique group identity and cultural norms of the group (Riley, 2013; Moon, 2016).

Positive communication and congenial relationships tend to be fostered in the group setting, allowing for the verbalization of strong emotions and the sharing of common experiences. Adolescents with experiences of trauma and abuse must often relearn how to trust others, which necessitates the role of a safe and contained group dynamic in therapy to establish

new connections with others. The "commonality" (Madigan & Gamble, 1992, p. 125) of a group offers reassurance and comfort that one is not alone in their trauma. Shared community experiences also restore a sense of empowerment through positive interactions with group members. The group may also be viewed as "collective empowerment" (Herman, 1992) from which one's involvement in healing includes taking an active role in expressing, supporting, reassuring, and sharing with others (Yalom & Leszcz, 2020).

## Art Therapy and Eating Disorders

Tables 1-4 in Appendix A will highlight the current state of literature for AT for ED treatment. Findings are grouped as psychodynamic and trauma-informed therapeutic functions and mechanisms of change below.

### *Psychodynamic Therapeutic Functions & Mechanisms of Change*

**Bypassing Verbal Defenses.** Art therapist Hinz (2006) has extensively worked with clients with EDs and notes that many individuals with EDs heavily rely on verbal defense mechanisms such as intellectualization in verbal therapy to protect themselves and maintain control of their world and narrative. Reliance on such defense mechanisms may slow the therapy process and impede the deeper processing of challenging feelings (Hinz, 2006). Mitchell (1980) postulates that art, in contrast to words, offers a sense of control in the expression of emotions, which may present a less threatening form of expression. This visual form of expression may enable clients to participate in therapy without solely relying on verbalization (Bucharova et al., 2020) and potentially bypass verbal defenses that may emerge (Levens, 1995). Art-making may also provide a greater expressive range than words alone through concrete, kinesthetic, sensory, and tangible ways (Hinz, 2006; 2020). In expressing oneself through art, the confusion and ambivalence adolescents with AN may try to conceal can be externalized on paper and used as a mirror and container in increasing bodily and self-awareness and clarifying the role of the ED in a cathartic way (Griffin et al., 2023; Levens, 1995; Wood, 1996).

**Symbolism of Food and Art Materials**. From a psychodynamic framework of conceptualizing EDs, Schaverien (1994a, 1994b) and Chafe (1995) theorize that a client's relationship to food may serve as a symbol and mediator between one's internal psychic world and their external world. As psychoanalytic views conceptualize AN as attempts to resolve inner psychological issues through physical means (Wolf et al., 1986), the art medium can provide a similar function, acting as an outlet, transitional object (Winnicott, 1953), and "transactional

object" (Schaverien, 1994a, 1994b) enabling discussion on maladaptive eating behaviours and preoccupations with body image without the explicit mention of food (Fleming, 1989). As such, a client's artwork and use of art materials are proposed to unconsciously parallel or become a substitute for a client's ways of relating to food, body, self, and their ED (Acharya et al., 1995; Lubbers, 1991; Matto, 1997; Rust, 1992; Schaverien, 1994; Wood, 2000) as an object of transference (Schaverien, 1994a, 1994b). The presence of the art as a third client, transitional object, and "transactional object" (Schaverien, 1994a, 1994b) also contributes to the triangular relationship between client, art, and therapist inherent to AT, which touches on themes of relational and attachment work.

While AT may not directly touch on treatment goals of increasing food intake or nutrition in individuals with AN, art materials serve as a tool and alternative mode of expression for individuals to experiment and confront their beliefs about food, or even replace self-damaging food-related behaviours (Makin, 2000a; Schaverien, 1989). Art materials and food share many commonalities – they are tactile, solid, or liquid, have textures, can be colourful, and can be transformed in different ways. AT interventions with individuals with an ED are suggested to allow individuals to challenge and modify their beliefs about food through the safe exploration of art materials. (Brooke, 2008). Notably, through an attachment lens, Makin (2000a) writes: "As a mother provides her child with food, an art therapist provides art materials to her patient" (p. 44).

**Challenging Perfectionism and Control.** Makin (1994) believes interaction and play with art materials can help encourage clients with EDs to let go of rigid control. Individuals with AN, for example, may frequently gravitate towards seeking control, predictable routines, and structured environments, while exhibiting protective behaviours that could be seen as rigid, ritualistic, or indicative of obsessive-compulsive tendencies. While limiting food intake generally gives those with AN a sense of being in control, it does not resolve underlying problems (Makin, 2000a). When clients can let go and spontaneously play with art materials, they may challenge their way of thinking and their ED's belief in perfection and control (Griffin et al., 2023; Naitove, 1986). Clients may also be able to confront their feelings about imperfection and losing control within a safe therapeutic environment when, for example, an image does not turn out as expected, or when one struggles with certain media (Betts, 2008). The process of AT may gradually increase an individual with AN's openness to spontaneity and experimentation in other aspects of life and recovery, allowing the individual to gain exposure to the ideas of letting loose,

making mistakes, and being imperfect within a safe and contained space (Griffin et al., 2023). Engaging with positive risk-taking and experimenting with different materials and ways of using materials may promote flexibility and adaptability (Griffin et al., 2023). Once clients are comfortable with the freedom of letting go, they may confront and challenge their set-in-stone beliefs about their bodies, food, and behaviours.

**A Channel for Disordered Behaviours and Thoughts.** ED behaviours are often seen as communication tools and expressions of distress (Landau-West, 1999). Art therapists theorize that AT may be integrated into verbal therapies and into the lives of individuals experiencing an ED as healthier coping mechanisms with the potential to replace self-damaging behaviours such as bingeing, purging, starving, and/or excessive exercise (Makin, 2000a; Fleming, 1989). Specifically, AT may provide an alternative to destructive ED behaviours and thoughts through the process of artistic sublimation, allowing for a client's cognitions and emotions to be discussed, channelled, and explored through art-making, rather than being channelled through a preoccupation with food. In two key studies in Griffin and colleagues' (2021) systematic review, Chaves (2011) and Thaler and colleagues (2017) also found AT was a helpful distraction from challenging thoughts and feelings of EDs, by allowing a break for clients to focus on physical art materials and the act of creating. The art product and creative process may also help the individual convey their perceptions of self, challenging relationships and unconscious dynamics (Bucharova et al., 2020). Expressive arts therapies also help individuals with an ED foster a trusting relationship between client and therapist, and, in turn, between themselves and their bodies (Betts, 2008).

**Separation and Externalization.** In her work with ED clients, Betts (2008) remarks that many clients consider their ED as a false provider of safety and security that eventually becomes internalized as a part of their identity. Naitove (1986) conceptualizes that the ED may serve as a friend, whose absence in a client's life may result in emptiness. Many clinicians recommend using language to separate and externalize a client and their ED. For example, expressing a client *has* AN, rather than *is* anorexic (Lask & Bryant-Waugh, 2013; Lask & Hage, 2013; Betts, 2008). Just as a medical illness is viewed as a distinct entity, so is "the anorexia" (Lask & Bryant-Waugh, 2013). Treatment can be conceptualized as working with the client against the ED, rather than against the client. AT supports the physical externalization of an ED, aiding clients in viewing a tangible differentiation and separation of the ED from their identity and sense of self

(Betts, 2008).

### *Trauma-Informed Therapeutic Functions & Mechanisms of Change*

**Promoting Safety.** AT may be conceptualized as a triangular relationship, where the artwork acts as a "third client" and mediator between therapist and client (Matto, 1997; Schaverien, 1994; Wood, 2000). From the client's perspective, relating to and connecting with the therapist through an art image rather than directly through words may facilitate a non-intrusive relationship that respects the client's need for safety and privacy in the early stages of therapy (Ki, 2011; Butryn, 2008). The use of art can reduce anxiety and resistance to the therapeutic process, helping focus therapeutic work on relevant issues as a medium of communication between self and environment and between client and therapist (Hunter, 2016; Matto, 1997). Through an attachment-focused lens, the triangular relationship of AT reinforces the holding environment the therapist creates for the client (Winnicott, 1971) and the creation of earned secure attachment (Schore & Schore, 2008; Findlay et al., 2008) through the consistency and predictability of the therapist, environment, and materials.

**Promoting Sense of Self and Identity.** Existing grey literature on the pathology and treatment of AN highlights clients' inability to perceive themselves as having a strong sense of self and identity (Woodhead et al., 1998). The creative process of art-making and AT facilitates freedom of self-expression, imagination, and autonomy (Acharya et al., 1995; Wood, 2000). Images of one's own making involve active engagement, self-directedness, and self-expression, serving as a "functionally or a symbolically meaningful self-representation" (Macks, 1990, p. 24), which may promote a less passive and more empowered sense of self and identity (Levens, 1987). Art-making also provides opportunities for new meaning-making (Fleming, 1989), seeing beyond symptoms and one's illness (Hinz, 2006), and exploration of unfamiliar areas of the self in stepping outside comfort zones through play and experimentation (Griffin et al., 2023). Similarly, art therapists Hinz (2006) and Luzzatto (1994) theorized that, for individuals with EDs, art-making may promote positive ways to relate to the self, which has been supported by Ki's (2011) qualitative interviews of participants in an arts-based ED support group. Participants described experiences of developing insights and connecting with the positive aspects of themselves, separate from their EDs (Ki, 2011).

**Increasing Self-Efficacy, Self-Esteem, and Mastery.** It has been proposed that a profound sense of ineffectiveness (Bruch, 1973, p. 155) may underlie EDs and trauma. Actively

involving clients in their treatment is suggested to promote autonomy, and improve self-efficacy and self-esteem, leading to positive changes in disordered behaviours and the establishment of earned secure attachment (McFarland, 1999). Lev-Wiesel and Doron **(**2004) support this notion, asserting that allowing clients the opportunity to choose their materials and models of non-verbal therapies can heighten their commitment to the therapeutic process and improve therapeutic outcomes (p. 267). By translating and transforming difficult emotions and impulses into art, clients may develop a sense of control over challenging behaviours and reactions (Fleming, 1989; Hinz, 2006). Individuals with EDs may also gain a sense of self-efficacy when experiencing mastery of art materials (Betts, 2008). To highlight this, the oscillation between directive and non-directive sessions within the Griffin and colleagues (2023) group AT structure allowed for containment and control that is often needed in clients with AN, paired with gradual personal experimentation, risk-taking, and mastery conducive to recovery.

Chaves (2011) found positive outcomes in adolescent ED clients' self-esteem through the therapeutic art book which allows clients to visually document their journey through their hospitalization and recovery. Specifically, qualitative interviews with participants indicated that through art-making within the contained boundaries of a book, individuals were provided with a container of individual emotions, thoughts, and challenges, while promoting meaning-making through narrative approaches. Griffin and colleagues (2023) also use an art book intervention, where participants reported increased pride and a sense of relief upon completion of their art book, with the tangible nature of artworks supporting feelings of accomplishment and productivity.

**Reconnecting with the Body.** In AT, clients with EDs have the opportunity to experience and acknowledge their bodies and their body's capacities to create and express through art in a way that develops a sense of autonomy and identity. In considering trauma as manifested in the mind-body split in individuals with EDs, Wood (2000) suggests the embodied use of art materials as providing a bridge between the self (where creativity originates) and the body (which creates the art). Through art-making, these separated spheres are brought together in an integrated mind-body approach, as described in the Bodymind model (Czamanksi-Cohen & Weihs, 2016). The integrative nature of art-making, which may include sensory, kinesthetic, cognitive, perceptual, affective, symbolic, and creative dimensions (Hinz, 2020) may also engage the entire body and bodily sensations in reconnection and reintegration. Art materials

emphasizing sensory experiences also provide opportunities to reconnect with the body through tension release, pleasure, and psychological grounding (Griffin et al., 2023; Malchiodi, 2014, 2020, 2021; Malchiodi & Crenshaw, 2014).

**Increasing Self-Awareness**. Art-making can increase self-awareness through the expression of unconscious content paired with the opportunity to confront, acknowledge, examine, and accept unconscious emotions, thoughts, and memories alongside an art therapist (Acharya et al., 1995). While EDs are not only about food, a symptom characteristic of all EDs surrounds the individual's relationship and feelings towards food and their body, and individuals may improve this relationship through art-making and AT. Driven by a need for control through their ED, individuals learn and gain mastery of their actions through art-making, where they can safely confront their psychological issues and relationship with food to fully understand themselves, their body, their power, and their capability to recover (Brooke, 2008). The externalization of thoughts and feelings through a visual medium may also allow for greater distancing and in turn, allow for greater insights into the self (Griffin et al., 2023).

**Discussion and Conclusion**

Given that the onset of AN is most prevalent in adolescence and emerging adulthood (Favaro et al., 2009; Halmi et al., 1979; Lucas et al., 1991; Micali et al., 2013; Solmi et al., 2021; Steinhausen & Jensen, 2015) and this age group experiences poorer treatment outcomes (Abbate-Daga et al., 2007), it becomes evident that additional research is needed to develop intervention and prevention programs to address current gaps in treatment (Allen et al., 2022). Specifically, gaps in ED literature suggest a need for interventions considering attachment theories and contemporary trauma-informed approaches for the treatment of adolescents with AN. This preliminary literature review aims to address current findings on AT approaches for this population and avenues for integration and intersections informed by these frameworks.

Existing literature on AN in relation to attachment trauma and AT primarily consists of dated theoretical psychodynamic writings. Some of the older psychodynamic literature tends to heavily pathologize the person, which may have fit the psychiatric environment of the time; however, there is a noticeable gap in the literature and practical outcomes addressing attachment-focused and trauma-informed approaches (Tasca, 2019). Implications for the integration of AT as a trauma-informed practice adjunct to current multimodal approaches could help bridge these existing gaps in the literature to address trauma and attachment injuries in childhood and

adolescence as they pertain to the etiology of AN. What has been highlighted from this literature review is the impact of attachment injuries and relational traumas in the development and maintenance of AN. By reviewing the evidence base and theories for the implementation of AT for ED treatment, the integration of AT frameworks such as the ETC (Hinz, 2020; Lusebrink & Hinz, 2022), ATR-N (Hass-Cohen & Findlay, 2015), and Bodymind model (Czamanski-Cohen & Weihs, 2016) provide avenues for integrating psychodynamic literature with modern attachment theories (Schore & Schore, 2008) into practice while addressing the attachment needs of this population. In providing avenues for integration, there are already many overlaps in psychodynamic, attachment-focused, and trauma-informed approaches in the literature that have not yet been tied together. For example, the presence of the triangular relationship in psychodynamic literature contributes to relational approaches outlined in modern attachment theories relating to attunement: the idea of art materials as nurturing (Moon, 2016) "food" provided by the therapist (Makin, 2000a), which touches on psychodynamic writings and attachment themes, as outlined in the Bodymind model (Czamanski-Cohen & Weihs, 2016). The goal of this intervention plan will be to tie these theories together and bridge them into psychodynamic, attachment-focused, and trauma-informed practice.

In considering the validity and reliability of the outlined literature, there is a noticeable lack of practice-based studies on the use of AT with ED populations. Within the field of EDs, specific AT interventions and intervention plans are rarely outlined in the literature. With these factors combined, there is a necessity to ensure validity by formulating a detailed session-by-session intervention plan for this study, addressing goals, outcomes, activities, and materials.

As Tasca (2019) summarizes, emotional regulation and emotional connection should be a focus of AN treatment to address attachment needs; key considerations moving forward include the identification of intersections between AT and attachment-focused and trauma-informed interventions to address this goal within a group AT setting. This would entail the specification of program theories (Fraser & Galinsky, 2010) and the development of an intervention plan. The following section will outline pertinent AT programs to inform the development stage of the current theoretical intervention research. Important questions to consider include: "How might group AT address attachment trauma in providing a secure base for adolescents with AN to revise their responses to create more secure and positive relationships with others?"; "How might group AT promote earned secure attachment in conjunction with promoting recovery from

AN?"; "What specific AT interventions would address these gaps?".

## Chapter 4. Literature Review: Program Theories

Given the scarcity of practice-based peer-reviewed studies on group AT with EDs in PHP settings, it will be important to draw knowledge from other fields to explore interventions that may inform this study's intervention design. This section will summarize pertinent peer-reviewed, practice-based, qualitative, and quantitative studies using the program theory exclusion/inclusion criteria. The aim is to utilize findings from the literature review to further the search for practice-based AT studies that will inform the development of program theories and interventions in Chapter 5. The following AT studies will focus on diverse populations, touching on relevant aspects such as population or challenge of focus, framework used, and/or structure of group AT sessions. Table 5 in Appendix A will explore the relationships between these studies and the research question as they relate to the program theory.

The review will begin with a focus on the current state of the literature on AT and EDs, followed by an exploration of adjacent and relevant AT programs that fit the inclusion/exclusion criteria of trauma-informed, attachment-focused, mind-body approaches to AT, and/or AT with adolescents. Due to the scope of this paper, not all studies will be examined in depth. The following studies are chosen for their specific nature and relation to the research question.

### Art Therapy Groups for Eating Disorder Treatment

Group AT settings for ED treatment may allow for increased self-expression, personal sharing, inclusion, and collaboration of other participants in one's creative process (Morenoff & Sobol, 1989). Art-making in this communal setting provides an outlet for clients to connect and relate with themselves and others (Wood, 2000), fostering benefits such as increased commitment to therapy through group alliances, reduced isolation, witnessing and learning from others at various stages of recovery, increased mutual support, and a sense of belonging that promotes interpersonal skills and self-esteem building (Lubbers, 1991). Group therapy may offer opportunities to decrease isolation, create a non-threatening environment for containment and sharing, and foster a space for connection and resonance (Piazza et al., 1983). Griffin and colleagues' (2023) feasibility study echoes these concepts, with participants sharing that the AT group offered a sense of connectedness, understanding and acceptance. Specific mechanisms of change include a sense of togetherness while allowing opportunities for individuality within a non-judgmental space of mutual understanding (Griffin et al., 2023). In particular, the use of

group murals or collaborative projects can facilitate the normalization and validation of individual experiences within the group, as they allow for the exploration of how one client's story and experiences intersect with those of others (Matto, 1997).

**Structured Sessions and Open Studio in a Partial Hospitalization Program.** Griffin and colleagues (2023) present a seminal study using a person-centered, recovery-oriented AT approach to working with individuals with EDs in both a directive and open-studio group AT structure. The study proposes a 2 sessions-per-week structure within a PHP, incorporating findings from their mixed-methods systematic review (Griffin et al., 2021). The first session of the week is a structured session focusing on directives, themes, and specific interventions (the scribble, blind drawings, clay throwing, round-robin visual poem, sensory guessing, sensory meaning-making with symbols in nature, group drawing at arm's length, terrarium making, and creating letters to/from the artwork as a closing), while the second session of the week serves as an open studio with an arts-demonstration (visual diary making, using fluid materials, exploring clay, making slime, ink marbling, lino-printing, using crepe paper with water) to promote autonomy, experimentation, self-determination, decision-making, and positive risk-taking. The choice of art materials for both sessions was informed by the ETC (Hinz, 2020). Although not explicitly stated as trauma-informed, the session structure follows Herman's (1992) stages of trauma-informed practice, with themes and approaches touching on ETC, ATR-N, and Bodymind-informed approaches through self-expression, self-regulation, and co-regulation via the relational-group setting. For example, unfamiliar areas of the self are explored during art-making as participants venture outside their comfort zones using grounding and sensory-based materials, while promoting a mutual sense of connection, understanding, and acceptance. Relating specifically to trauma-informed practice, Week 1's introduction to the frame and AT through the gentle introduction to art-making through collage lays the groundwork to establish safety and stabilization while addressing perfectionism. Week 2's open choice of media promotes flexibility, Week 3's self-box, combined with Week 4's theme of letting go/holding on, Week 5's theme of transformation promotes remembrance and mourning of personal experiences, while Week 7 addresses reconnection and integration.

**Feminist Art Therapy Case Studies.** Edwards' (2005) thesis project details a 10-week feminist-informed AT group for adults with AN. She outlines week-by-week themes, interventions, discussions, and responses from participants in a dual-case study design.

Specifically, themes focus on power, self-image and safety, inner critic, image of the eating issue, wants and needs, refocusing, self-care, and celebration. Proposed interventions include round-robin drawings as a group, weekly journaling as a beginning ritual, and the following directives: create a self-portrait as an animal in a safe place and an unsafe place, create an image of the inner critic, create a representation of the eating issue, depict wants and needs, create a self-box, create a self-care collage, and create a "hand" collage with messages to take home. A strong focus on collage work was promoted in response to proposed group themes. The inclusion of client responses and feedback to interventions and the group provides strengths and additional support for the design and implementation of the group structure.

## Mind-Body Approaches to Art Therapy Groups

### *Role of Emotion Processing in Art Therapy (REPAT)*

Czamanski-Cohen & Weihs (2023) introduce the development of the role of emotion processing in art therapy (REPAT) intervention, an 8-week AT intervention informed by the Bodymind model (Czamanski-Cohen & Weihs, 2016) to target emotion processing as a primary mechanism of change. In the 8-week group with women coping with breast cancer, sessions begin with a 10-minute rapport-building discussion, where art therapists begin by creating a safe environment through the triangular relationship to promote engagement with the self through art-making. This is followed by a brief relaxation exercise, 40 minutes of art-making, and ending with 30 minutes of processing and discussion. Interventions include the creation of a safe place, "playing" with materials in an open studio setting, making a drawing about an emotion, creating an image about something distressing and a subsequent drawing where one element of the distress drawing is changed, drawing two sides of a current conflict, creating art using body outline templates, and a portfolio review for the last session.

## Trauma-Informed Art Therapy Groups

Many studies have detailed the implementation of trauma-informed group AT for post-traumatic stress disorder (PTSD; Schouten et al., 2018), complex-PTSD (Luzzatto et al., 2022), sexually abused children (Pifalo, 2011), victims of genocide (Chu, 2010), and refugee children (Ugurlu et al., 2016). Most trauma-informed AT groups utilize a framework informed by Herman's (1992) trauma-informed phased-based approach. Specific interventions in these studies include: creating a safe place, collaging positive images, expressing traumatic and positive memories (Schouten et al., 2018; Jones et al. 2018); creating a body outline, a positive

relationship in childhood, the hidden seed, the sad/angry child (Luzzatto et al., 2022); creating a life roadmap (Pifalo, 2011); the inside/outside box (Chu, 2010); masks, breathing exercises, group puzzle, movement-based exercises (Jones et al. 2018); and sessions that integrate open studio processes with themes (Hass-Cohen et al, 2016; Luzzatto et al., 2023). Often, as the group concludes, there will be a collaborative project with peers to emphasize connection and honour positive attachment in a group setting (Luzzatto et al., 2022, Feen-Calligan et al., 2020, Sitzer & Stockwell, 2015, Griffin et al., 2023).

***Open Studio and Survivors of Military Suicide***

In their 2021 study on open studio groups with survivors of military suicide, Strouse and colleagues found significant quantitative improvements among participants in social validation, the development of new possibilities, and enhanced relational connections. Qualitative findings emphasized themes such as meaning-making, the opportunity for grieving, new perspectives, group bonding, a sense of calm, and present-moment awareness. The open studio group employed interventions such as collage and assemblage to increase a sense of control and facilitate meaning-making through a deconstruction and reconstruction process, memory books for tangible meaning-making, and the creation of dolls to provide companionship and a loving transitional object.

***Refugee Youth***

Syrian refugee youth were the focus of a 12-week AT group outlined by Feen-Calligan and colleagues (2020). The group aimed to alleviate stress and trauma-related psychopathology while offering coping skills. Their proposed intervention plan is extensively detailed, highlighting session goals, objectives, results, and therapists' co-determined recommendations for subsequent weeks. Key considerations include the establishment of a collaborative safe space for self-expression in the beginning phases, transitioning to stress reduction in the middle phase, and ending with self-exploration and personal and group narratives. Interventions include group yarn weaving, masks, clay work, breath drawing, a group puzzle, a strengths tree, tissue paper painting/collage, open studio, scribble chase, and puppet narratives and characters. The study concluded with positive outcomes, including reduced stress, diminished self-reported separation anxiety, and increased interest in art-making and coping skills. Notably, the group weaving fostered a sense of belonging, while kinesthetic exploration of media facilitated stress release (Hinz, 2020). Storytelling through puppets provided opportunities for participants to reflect on

values and make meaning of past experiences and self-narratives.

## Adolescent Art Therapy Groups

Several AT groups have been conducted with various adolescent populations. Interventions include masks and group paintings (Huang et al., 2021); the sign-in wall, art journaling, gender roles collage, and polarity drawings (Riley, 1999); the metaphorical family tree, personal totem (Thomas, 2011); altered books (Chilton, 2007); the inside/outside box (Chu, 2010); the group city/town (Slayton, 2012), and open studio (Kelemen & Shamri-Zeevi, 2022).

### *At-Risk Youth*

Sitzer & Stockwell's 2015 study outlines their group AT work that integrates cognitive-behavioural therapy and dialectical behavioural therapy through a wellness curriculum for at-risk youth between the ages of 9 and 12 with the objective of promoting resilience. This wellness curriculum follows weekly modules that outline goals, art interventions, and post-artwork discussion over a 14-week period. Art interventions rely on best practices for art-based treatment for trauma as outlined by Collie and colleagues (2006) and they include the safe place mandala, draw someone you trust, the kinetic family drawing, the wheel of change, anger mandala, anger cake, anger thermometer, triangle of needs, bridge drawing assessment, silent mandalas, cards of classmate's strengths, island drawing, and a personal resilience shield.

### *Identity Development and Open Studio*

Kelemen & Shamri-Zeevi (2022) outline their open studio intervention to facilitate identity development while addressing mental health challenges in adolescents over a 10-month period. Their open studio interventions were informed by art therapist Edward Adamson's work in psychiatric hospitals in the 20th century. As Adamson's goal was to facilitate clients' self-expression, he did not provide guidance or direction to clients during their art-making experience, nor did he interpret their images (Hogan, 2001). Adamson provided a calm and patient environment with appropriate materials to facilitate the group's own creative process (Hogan, 2001). As a result, the open studio intervention as proposed by Kelemen & Shamri-Zeevi (2022) emphasizes "supported autonomy," which consists of giving participants as many choices as possible within a safe and contained environment. This promoted decision-making and initiative as participants learned how to be resourceful, make positive choices, select materials, and determine how they wished to use them. It should be noted that in this study, Kelemen & Shamri-Zeevi (2022) did not encourage sharing artwork among group members,

cultivating a group agreement that art creations were personal and represented aspects of the creator. They noticed that, as participants increased their connections and trust in one another, they began to show their work and share reflections with others voluntarily.

# Chapter 5. Results: Intervention Design

## Problem Theories

### *Identification of the Problem*

Through a qualitative content and thematic analysis of the relevant literature outlined in Chapter 3, the presence of attachment and relational traumas and subsequent emotional dysregulation were identified as the main challenges in working with and treating adolescents with AN from a trauma-informed lens. Specifically, emotional dysregulation stemming from attachment and relationship traumas entails the lack of capacity to handle stress and regulate emotions without external assistance (e.g., adaptive, or maladaptive coping mechanisms such as disordered eating; Schore, 1997; Cooke et al., 2005). AN behaviours such as food restriction and excessive exercise may be conceptualized as a form of emotional processing, regulation, expression, and communication in developing an autonomous sense of self by sublimating through the body through maladaptive means (Bruch, 1973, 1982).

### *Risk Factors*

Common risk factors identified in the synthesis of relevant literature presented in Chapter 3 include a) insecure attachment patterns (Cichetti et al., 1993; Bruch, 1973; Swift & Stern, 1982; Zaccagnino et al., 2017; Ward et al., 2011; Budia et al., 2022; Ward et al., 2000; Tasca, 2019), b) family dynamics (Minuchin et al., 1978; Evans & Street, 1995), c) the presence of ACEs and/or traumatic experiences (including relational and attachment trauma; Krueger, 1989; Finlay, 2018; Bruch, 1973; Swift & Stern, 1982, as cited in O'Kearney, 1995), and d) the adolescent developmental period of individuation and separation (M. Harrison, personal communication, January 19, 2024; Favaro et al., 2009; Halmi et al., 1979; Lucas et al., 1991; Micali et al., 2013; Solmi et al., 2021; Steinhausen & Jensen, 2015; Abbate-Daga et al., 2007).

### *Protective Factors*

Harrison (personal communication, January 19, 2024) notes in her 10+ years of practice as a child and adolescent pediatrician that all individuals experience trauma in different ways. She highlights that a protective factor in promoting clients' resilience from trauma is the strength of their family support and/or the quality of attachment relationships. Even one positive

attachment relationship characterized by unconditional care and love with a caregiver, mentor, therapist, teacher, or coach, can provide a secure base for self development and co-regulation following trauma (M. Harrison, personal communication, January 19, 2024; *The Science of Resilience*, 2015).

With this in mind, protective factors that suppress the risk factors outlined above are summarized under the themes of a) familial support, b) supportive relationships, c) earned secure attachment, and d) affect regulation. While these factors overlap significantly, they may not be mutually exclusive for individuals; however, an overarching requirement for such factors includes empathy, kindness, healthy boundaries, co-regulation and attunement, rupture and repair, and unconditional positive regard (M. Harrison, personal communication, January 19, 2024).

***Malleable Mediators***

Malleable mediators that address protective factors in AN include the use of a trauma-informed and attachment-focused approach to AT that emphasizes the importance of self-regulation, co-regulation, and emotional processing (Tasca, 2019) in repairing attachment wounds and trauma that may contribute to the etiology and maintenance of AN. Specific malleable mediators in the context of protective factors include:

**Familial Support**. Communication, boundaries (M. Harrison, personal communication, January 19, 2024), cohesion, and problem-solving skills (Minuchin, 1978; Bruch, 1973, 1978). Given that this proposed intervention plan will not address family-based therapies, this mediator will not be included as a focus in the program theories. This delimitation will be addressed through the use of an attachment-focused approach to group therapy.

**Supportive Relationships.** Communication, boundaries (M. Harrison, personal communication, January 19, 2024)), quality and availability of social networks, community belonging (Moon, 2016), interpersonal communication and conflict resolution skills, capacity to lean on others for support, and emotional connection with others (Tasca, 2019).

**Earned Secure Attachment.** The ability for trust and vulnerability in relationships (Zaccagnino et al., 2017), predictability and consistency of environment and relationships, responsive physical and affective attunement (Armstrong, 2013), effective rupture and repair (Schore, 2001), and co-regulation (Schore & Schore, 2008).

**Affect Regulation.** Self-regulation, co-regulation (Schore & Schore, 2008), and the

awareness, acceptance, integration, and processing of emotions. (Tasca, 2019)

Malleable mediators outlined may be matched with the following evidence-based change strategies: trauma-informed AT (Hass-Cohen, 2016; Hass-Cohen et al., 2014; Feen-Calligan et al., 2020), ATR-N (Hass-Cohen & Findlay, 2015), the Bodymind model (Czamanski-Cohen & Weihs, 2016), and group AT (Moon, 2016).

## Program Theories

### *Goals*

Art therapists have emphasized the importance of establishing a foundation of safety that precedes any treatment goals when working from a trauma-informed approach (Avrahami, 2001; Malchiodi, 2001). With this in mind, the primary goals of this AT group with adolescents with AN are emotional processing and emotional regulation through the following:

**Goal 1.** Experience a safe holding environment for healthy relationships and attachment through group dynamics and attunement with peers and therapist to promoting a sense of earned secure attachment (Schore, 2001; Findlay et al., 2008; Schore & Schore, 2008) and emotional regulation (Schore & Schore, 2008).

***Objectives.*** Foster and co-create a trusting, supportive, non-judgmental, and safe group atmosphere (1a). Promote emotional expression and exploration through self and co-regulation (1b).

**Goal 2**. Externalize, reflect, express, clarify, process, and integrate emotional experiences central to AN through art-making and group discussion (Jeong & Kim, 2006; Murphy, 1984, Fleming, 1989)

***Objectives***. Identify and externalize emotional experiences (2a). Foster reflection, clarification, and integration of emotional experiences through group discussion (2b).

**Goal 3**. Foster a sense of self-efficacy and agency over their recovery through the integration of experiences within the group and within art-making.

***Objectives***. Empower individuals through collaborative decision-making (3a). Promote autonomy, agency, self-efficacy, and mastery through art-making (3b)

These goals will be addressed through AT experiences within both directive and non-directive session structures conceptualized within an attachment-focused and trauma-informed framework that reflects Herman's (1992) stages of trauma-informed practice.

### *Action Strategy*

The proposed plan to address treatment needs and malleable mediators consists of an 8-week trauma-informed and attachment-focused AT group. The group structure will address malleable mediators outlined above with a focus on community belonging (Moon, 2016); emotional connection, processing, and regulation with others, (Tasca, 2019; Schore & Schore, 2008); the capacity to lean on others for support; the predictability and consistency of environment and relationships; responsive physical and affective attunement (Armstrong, 2013); and effective rupture and repair (Schore, 2001). The group format of AT tends to be a preferred mode of treatment in PHP settings, as the group dynamic works on several levels and systems simultaneously and is an agent of change in and of itself (C. York, personal communication, January 31, 2024).

### *Theory of Change*

The strategy for promoting secure attachment and emotional regulation in adolescents with AN involves both collaborative group AT experiences and individual AT experiences. Group AT experiences will be used to promote co-regulation and the establishment of a safe environment to set the stage for individual processing. Armstrong (2013) suggests that the ability to regulate emotional states provides the necessary safety for individuals to begin processing difficult emotions, experiences, and feelings to make meaning of them. Individual processing will enhance group processes through further integration of emotional experiences central to AN in order to foster a sense of agency and control over one's recovery. Returning the focus to group processes in the later phase of therapy promotes self-efficacy and the integration of experiences involving aspects of attachment in social relationships (Budia et al., 2023).

## Program Structures and Processes.

### *Location*

It is often believed that clients cannot completely engage in psychotherapy until they are medically stable as their brains are not nourished enough to "do the work" (Lester, 2019, p. 125). The inaccessibility and difficulty of psychotherapeutic work in the context of a malnourished brain may discourage clients who cannot engage in exploration, insight, and action at that time, resulting in a sense of failure, or even the feeling of being set up for failure (M. Harrison, personal communication, January 19, 2024). As a result, the PHP setting is chosen for this intervention design as clients in PHP are often medically stable and able to engage in psychotherapeutic work at this stage.

***Group Identification***

Art therapist Cynthia York (personal communication, January 31, 2024) shares that group selection for AT groups is often chosen based on the availability and interests of clients in a PHP program. Often, AT groups take a drop-in or community art studio approach. York (personal communication, January 31, 2024) outlines that with this open group participation format, emotional safety becomes the most important factor. For example, scheduling a group when one or more clients will be removed from the group for other forms of therapy would not be advised. Additionally, the art therapist is encouraged to prepare the new participant(s) before their first session by outlining group norms to ensure predictability and consistency (C. York, personal communication, January 31, 2024; Yalom, 2017).

In considering the ethical considerations regarding recruitment, specifically with providing and withholding treatment, it should be noted that most PHP settings treat a diagnostic mix of adolescents with EDs and comorbid diagnoses that are not limited to AN. With this in mind, it would be inappropriate to solely provide an AT group for clients with AN; however, Baudinet & Simic (2021) report that the majority of adolescents who attend PHPs are diagnosed with AN or EDs primarily characterized by restriction and weight loss. They outline that often in PHP settings, clients are grouped based on similar diagnoses for specialized groups, for example, an AN-based group to address AN-specific symptoms. This will be the chosen avenue for the recruitment of participants for this AT group within the PHP setting. In other words, the AT group will be described within the clinical team as a group for AN, similar to how some programs may provide specific groups for specific topics (Stewart & Williamson, 2004b). With this in mind, future research is needed to examine the integration of AT to address the needs of adolescents with other EDs such as bulimia nervosa, binge-eating disorder, other specific feeding and eating disorders, avoidant restrictive food intake disorder, rumination disorder, unspecified feeding or eating disorder, and atypical cases of EDs.

Oscillation of group participants and transient membership will be anticipated due to the ongoing admissions and discharges that are characteristic of this setting (Cameron & Kipnis, 2015). Consequently, the group will function as a semi-closed group wherein membership is contingent on referral by a multidisciplinary team member.

In terms of group size, Diamond-Raab & Orrell-Valente (2002) propose that group size is an important factor in the effectiveness of group and milieu therapy and should range from 6-10,

depending on the treatment unit at any given time. They recommend that groups meet regularly in the same setting, at the same time of day, for no less than 90 minutes (Diamond-Raab & Orrell-Valente, 2002).

### *Role of the Art Therapist*

The role of an art therapist can be defined as providing empathy, adaptability, soothing, tension modulation, and a nurturing and non-threatening environment. The art therapist serves as a guide in encouraging clients' experimentation, risk-taking, and problem-solving while acting as a mirror for the client(s) using the therapeutic relationship and through verbal and non-verbal reflection (Lachman-Chapin, 1979; Goodsitt, 1985). As the art therapist accompanies the client(s) in their therapeutic journey, they will modify materials, techniques, and interventions to meet the client's needs at each stage of development within the process of treatment (beginning phase, mid-phase, termination). Clients must be encouraged, not forced, to participate in their own treatment (Murphy, 1984), to interpret their own work (Levens, 1984), and to find their own solutions (Fleming, 1989) to promote individuation and autonomy. The art therapist should also be attentive to ways of engaging the reluctant and openly resistant client, with initial phases of alliance-building focusing on an interplay of sensitivity, empathy, and respect for the adolescent with anorexia (Herzog et al., 2004). Art-making may provide glimpses into the inner lives of adolescents, necessitating the role of the art therapist to understand the feelings, thoughts, and physical efforts embodied in an art piece (Moon, 2012). The major task of the art therapist in adolescent AT is to see what adolescents are trying to communicate through their art-making and respond in ways that honour these communications.

When working with adolescents with AN, the therapist should be mindful of the client's positive transference towards the therapist (Fleming, 1989). Given the common need to please others, clients with AN may ask for subtle requests for reassurance or praise (Thomson & Sherman, 1989), perpetuating the maintenance factors of their ED. Additionally, art therapists working on a multimodal team should maintain communication with other team members in the form of supervision, clinical rounds, and/or debriefs to avoid splitting and idealization on the part of the client (Lester, 2019). AT sessions should not be conditional upon the attainment of goals in other forms of therapy as this will impede the development of a trusting therapeutic alliance within AT (Schaverien, 1989).

**Therapeutic Engagement.** In considering the development of an effective and

collaborative therapeutic relationship, Nicholson (2013) outlines the importance of the therapeutic stance. Specifically, adopting a client-centered approach that conveys empathy, warmth, respect, curiosity, acceptance, humility, flexibility, supportiveness, honesty, and positive regard is likely to facilitate a strong therapeutic alliance and collaborative engagement. Moreover, it helps the therapist to be seen as a helpful collaborator in supporting treatment. With this in mind, therapists working with adolescents with AN are presented with additional challenges and must be aware of the adolescent's deep mistrust of relationships and the motives of others (Herzog et al., 2004). As such, the therapists should be empathic while accurately mirroring the adolescent's perceived wants, needs, and feelings. The therapist must also be tolerant, undemanding, consistent, and flexible while possessing skills in sharing and tolerating the adolescent's affect and experiences without denial, resistance, or criticism (Herzog et al., 2004). Hunter (2016) writes that therapists working within a positive psychology and creative expression framework, such as some art therapists, have an advantage in the treatment of EDs such that the client may benefit from the art therapist's ability to recognize and appreciate the unique qualities of each individual. Pertinent to adolescents seeking therapy and treatment, this clientele may have been subject to stereotyped perceptions and judgements from people and systems; they may not trust others to see them for who they are, much less trust their own perception of self.

Individuals with EDs also commonly report feeling fearful surrounding a therapist's "underlying agenda" (Hunter, 2016). Guided by an internal ED voice, clients may often feel that therapists form judgments on their appearance, shape, and weight, while also suspecting that the therapist's goal will be to force changes in body size or control the individual's eating and exercise behaviours (Hunter, 2016). Therapy may be viewed as invasive to the ED and the individual's sense of self as protected thoughts, beliefs, behaviours, loss of control, and potential shame are brought to light for judgment and extinction (Hunter, 2016). Maisel and colleagues (2004) stress the importance of the therapist understanding and empathizing with the persuasiveness and hold this ED voice may have on the individual and their perception of themselves and the world around them. Herzog and colleagues (2004) add that therapists must establish trust by acknowledging the adolescent's ongoing pain while recognizing the multifaceted nature of the disorder and acknowledging social, psychopathological, genetic, biological, behavioural, and familial factors.

***The Good Enough Therapist***. As with the idea of the "good enough mother" (Winnicott, 1960), the "good enough therapist" does not need to be perfectly attuned at all times. Schore (2001) emphasizes the dynamic of rupture and repair in a therapist's attunement and regulatory experiences while reinforcing the importance of re-established security after misattunement over perfect attunement, which is not often possible or desirable. Moustakas (1995) describes "being-in, being-for, being-with" the client as a process of developing attunement. This process is further outlined by Moon (2016): as group members feel understood through the AT processes, artworks are accepted and regarded as an ally, while involving the creation of an I-Thou relationship among group members facilitates positive moments and collaboration among the facilitator(s) and group members (p. 15).

**Art Materials.** The use and provision of art materials will be considered through a trauma-informed lens informed by the ETC (Hinz, 2020; Lusebrink & Hinz, 2022).

Given the parallels between art materials and food, Fleming (1989) recommends non-threatening materials (pencils, markers, crayons) in the initial stages of AT treatment, as these are often reassuring and calming, and encourage cognitive responses. As individuals with AN often demonstrate strengths in their intellectual abilities, cognitive responses may feel more familiar and accessible. In other words, the "control" that the client with AN values so much may be worked with, not against (Mitchell, 1980). Fleming (1989) adds, "As does the 'good enough' mother, the art therapist supports the patient's risk-taking and solution-finding. The art therapist also respects the patient's need to retreat for comfort and soothing by providing structured use of art materials" (p. 283).

Fleming (1989) suggests that during the mid-stage of therapy, it is beneficial to express affect and engage in self-investigation using more fluid materials like soft pastels and paint. Conversely, Fleming (1989) warns against using thick paint, which could smear and run, bearing a resemblance to bodily fluids. "Goopy" materials such as thick paint and clay may invite regression yet support reintegration at a later stage depending on the client's progress. The return to safer and more soothing materials may be a point of containment for the client who may regress in treatment (Fleming, 1989). At the termination stage, exploration of loss and regression to earlier needs may be explored by examining previous artwork. Viewing artwork made during the initial and mid-stages of therapy may be reconsidered as facilitating an exploration of anxiety, rage, and guilt, while simultaneously supporting self-understanding, a cohesive sense of

self, and constructive defenses (Fleming, 1989). Returning to art materials used during the initial stages of treatment helps with closure, as "control over the art material provides a substitute, or outlet, for wishes of control previously manifested in eating behaviour and preoccupation with body image" (Fleming, 1989, p. 285). Required materials will always be provided and put out by the art therapist for directive sessions (Sessions A) and optional skillshares (Sessions B), however, participants are always welcome to gather their own materials of interest for directive and open studio sessions.

**Confidentiality.** Artwork should be kept and protected in a confidential and locked cabinet to promote its role as a protected transitional object (Fleming, 1989). The client will be given the freedom to destroy or hide their artwork should they choose to do so at the end of the therapy. The exception to the art therapist keeping all client artworks is if the client terminates early due to discharge and for the comfort books intervention in Session 3A.

***Structure***

As the length of stay for PHPs ranges from a month or less (Hayes et al., 2019; deGraft-Johnson et al., 2013; Knatz et al., 2015**)** to 6 months or more (Girz et al., 2013; Grewal et al., 2014), this proposed group will be informed by Griffin and colleagues' (2023) pilot study structure and will implement a 10-week group AT programming consisting of two sessions per week for a total of 20 sessions total. The first session of the week will take on a closed group format, with the second taking an open studio format. All sessions will last for 90 minutes each. The first group of the week will be referred to as "Sessions A", which follows the structure of a directive AT group, while the second group of the week will be referred to as "Sessions B" which will follow a non-directive, open-studio AT approach.

**Sessions A & B Structure.** The following section will outline the general structure for Sessions A and B. Rituals, reflection and closure will remain consistent for Sessions A and B; however, the warm-ups and art-making portion will differ between sessions.

***Rituals and Creation of the Holding Environment.*** As outlined by Moon (2016) and Diamond-Raab & Orrell-Valente (2002), rituals and consistent procedures are designed to provide a sense of predictability and safety to group members while also allowing members a measure of control. Beginning rituals will include a sign-in wall (Riley, 1999) followed by members sitting in a circle at the table when they arrive and going around the circle to discuss roses (highlights), thorns (challenges), and buds (things to look forward to) of the week.

***Warm-Up.*** Many creative arts therapists outline that warm-up activities are intended to relieve group members' anxiety and promote feelings of safety, facilitate spontaneity by connecting group members to the ''here and now,'' release tension, allow a group theme to emerge, facilitate group members' self-expression and self-exploration, and orient to the AT space (Diamond-Raab & Orrell-Valente, 2002; Dayton, 2004; Griffin et al., 2023). Warm-up art activities will be brief and will be guided by relational, sensory, and kinesthetic-based exercises (Hinz, 2020).

***Art-Making in the Studio Space.***

**Sessions A.** Warm-up activities will be directed in Sessions A. These sessions will take on a traditional, structured, art psychotherapy group process with a focus on themes (Liebmann, 2004). It will roughly adhere to the following pattern: 10-30 minutes for beginning rituals, warm-up (directed), and introduction of the theme; 20-45 minutes of art-making; 30-45 minutes of sharing, and 5-10 minutes for closure (Liebmann, 2004). The timeline of the session will be announced at the beginning of each session to reduce participant anxiety. Conversations among participants during art-making are encouraged.

**Sessions B.** These sessions will take on a more open-studio approach to AT (Allen, 1995; Moon, 2016), informed by emerging themes or interests from group participants. Warm-up activities will be self-directed. These sessions will emphasize self-directed artistic processes to promote autonomy, decision-making, mastery, attunement, self-regulation, co-regulation, and the predictability and consistency of the art studio. Due to the high prevalence of anxiety among this population to create art without direction (Swinbourne et al., 2012), a brief skillshare or demonstration on how to use a specific art material will be offered at the beginning of each session, informed by Griffin and colleagues' (2023) study. Brief and optional skillshares led by the art therapist will be presented at the beginning of the session and participants can either participate in the skillshare or engage in their own art-making for the rest of the session.

***Sharing.*** Although sharing may occur and is encouraged throughout the sessions, there will be dedicated time at the end of the session for discussion. Content sharing will come from individual participants; however, the art therapist will have discussion points to integrate and suggest based on predetermined themes or themes that emerge in the session. The goal of this stage is to promote group cohesion through reconnection, mutual empathy, and identification

while facilitating containment.

***Closure.*** Closing rituals entail participants sharing something they wish to leave behind in the group and something they want to take with them. In addition, participants will add a mark, pattern, or symbol to the sign-in wall (Riley, 1999). These rituals will assist in closing the space and group and aiding participants in transitioning back outside of the AT studio.

**Sessions Overview**

The following section will briefly summarize the proposed interventions and the structure of the program. Note that the following description of sessions (both Sessions A and B) will all include the same beginning and closing rituals and sharing periods as outlined above. For this reason, those stages of each session will not be outlined in the session descriptions below. A more detailed overview of the proposed session structure including the stage of therapy, main group goals, malleable mediators, session objectives, structure, interventions, and materials needed is available in Appendix B.

***Phase One - Safety and Stabilization and Overcoming Dysregulation***

The goal of phase one is for clients to experience a safe holding environment for healthy relationships and attachments through group dynamics and attunement with peers and therapist to promote a sense of earned secure attachment through rupture and repair (Schore, 2001; Findlay et al., 2008; Schore & Schore, 2008), non-verbal communication, co-regulation (Schore & Schore, 2008), and expression. This will be achieved through the art therapist's containment and holding of the space, promotion of communal belonging and relational safety, consistency of the environment, and introduction of activities exploring self and co-regulation (Malchiodi, 2020). Co-regulation will be promoted through the relational conditions between the art therapist, artworks, clients, and group dynamics with an emphasis on mirroring and attunement, communal flow (Csikszentmihalyi, 1997), group experiencing (Czamanski-Cohen & Weihs, 2016), and the working alliance.

**Session 1A.** The first session is described as one of the most important aspects of treatment for clients with EDs. The therapist must be able to emphasize the process of joining with clients in a creative and safe environment that fosters trust and hope (Hunter, 2016). It is within the first session that clients are introduced to the style of the art therapist, the framework of AT, and other group members. This first session provides the necessary foundation to reduce fear and promote hope in the healing process and course of therapy (Hunter, 2016).

An introduction to the space, materials, the role of the art therapist, and the frame of therapy is provided by the art therapist. Group members will then introduce themselves by preferred names and any preferred pronouns. The art therapist will then facilitate a discussion regarding hopes and fears for the group and for AT. *Group guidelines* written on paper will be established collaboratively and will be secured on the wall, which can be added to in future sessions. The art therapist will then introduce a *scribble drawing* as a warm-up activity (Hinz, 2006). The main intervention will be the creation of a *safe space within a container* (e.g. in a pre-drawn circle, border or frame around the paper) using collage to provide containment (Fleming, 1989). Participants will be encouraged to explore the five senses (touch, smell, taste, sounds, sights) in creating a collage of their safe space, either concretely or abstractly (Czamanski-Cohen & Weihs, 2023; Sitzer & Stockwell, 2015; Schouten et al., 2018; Jones et al., 2018; Hinz, 2006; Sitzer & Stockwell, 2015). Collage will be used for its accessibility to various populations and connection with potential client anxiety to art-making (Feen-Calligan et al., 2020; Hinz, 2020). The group will conclude with optional sharing after art-making. Discussion points from the art therapist may include individual and collective needs for safety and the integration of everyone's safe space into the group dynamic and art studio.

**Session 1B.** The first open-studio/optional skillshare AT session will focus on introducing the frame of the sessions and differences compared to the directed AT sessions from earlier in the week. The structure of these sessions will be framed as a place for artistic exploration and experimentation, connection with other participants, and exploration of personal interests through creative processes. The optional skillshare for this session will be *"playing" with different art materials* ranging from fluid to resistive (Czamanski-Cohen & Weihs, 2023; Hinz, 2020, Hinz, 2006; Lusebrink & Hinz, 2022; Graves-Alcorn & Kagin, 2017). A large sheet of paper will cover the entirety of a table for the art therapist to demonstrate the common use of different materials as well as their experimental uses and combinations. Participants interested in the skillshare are encouraged to try making marks with the different materials and combinations of materials on the shared piece of paper alongside other group members and the art therapist to promote sensory interaction, co-regulation, attunement, autonomy and agency (Czamanski-Cohen & Weihs, 2016). Discussion or sharing points may include preferences for media, how different materials may elicit different responses, and the experience of bodily sensations when using different materials to promote bodily awareness. Those who choose not to participate in

the skillshare will also be invited to share their thoughts, processes, or art-making.

**Session 2A.** The session will begin with *round-robin drawings* (Edwards, 2005; Liebman, 2004). Each participant will be given a sheet of paper and drawing materials. Participants will be instructed to choose one material to use throughout the activity. They will each make a mark or drawing on their paper for two minutes. Everyone in the group will then move clockwise to the next spot and add to another group member's drawing with their chosen material for two minutes. This process will repeat until participants return to their original drawings. Brief discussion points may include the co-creation of images to form whole pictures and finding one's mark among the group.

The main intervention will include *collective pie* (Smallwood, 2019). A large Bristol board circle will be cut into slices, with the number of slices depending on the number of participants in the group during the session. Each group member will be given a piece of the pie to create an artwork using controlled and non-threatening art media (e.g. pencils, pencil crayons, markers, crayons) to represent their goals for therapy and recovery. At the end of the session, individual pie pieces will be reassembled as a collaborative effort to reflect on group goals. Discussion points will include individual and collective goals while promoting community belonging through physically coming together as a group through art-making.

**Session 2B.** *Shaving cream paint marbling* using a mediator (e.g. paintbrush, stick) may give participants a level of safety and reflective distance during this initial stage of therapy in working with more fluid materials (Fleming, 1989). This intervention will promote stress reduction, sensory stimulation, mindfulness, and mastery in creating unique art images.

**Session 3A.** For the brief warm-up activity, participants will find a partner to engage in *dyadic non-verbal communication* (Graves-Alcorn & Kagin, 2017) on large mural paper taped on the wall. Dyads will take 5 minutes to communicate with a partner via art-making using only line, form, colours, and body language. This activity will aim to introduce nonverbal creative communication to participants who may feel nervous or silly doing drawings, with free forms and lines eliminating the perceived pressure to produce a "good" drawing.

For the main intervention, participants will use pre-existing hardcover thrifted books to alter the books and create their own *comfort books* (Chilton, 2007; Chaves, 2011; C. York, personal communication, January 31, 2024). The purpose of comfort books is to provide comfort and soothing for clients in hospitals through images and words of hope and recovery **(**C. York,

personal communication, January 31, 2024). Collage with found objects, postcards, images, patterned papers, words, wallpapers, magazine clippings, maps, and textiles is described as an emergent process for clients who struggle with perfectionism (Cameron & Kipnis, 2015). For the comfort books intervention (C. York, personal communication, January 31, 2024), participants are invited to visually document their journeys and re-author their own narrative of recovery within the containment of a book. Themes of construction, co-construction, de-construction, re-construction, and personal narratives will be explored as a group. This project will also serve as a transitional object for participants to work on outside of sessions. The length of the book may contribute to a time-consuming process of altering and personalizing. Consequently, participants are invited to bring their comfort books to subsequent sessions. If time permits, they can work on them individually or share them with other group members.

**Session 3B.** The art therapist will provide an optional skillshare for creating *sock monkeys* (C. York, personal communication, January 31) or a *rag doll* (Feen-Calligan et al., 2009) using basic sewing or gluing techniques. This project will promote discussion topics on interpersonal touch (Hass-Cohen et al., 2015), attachment, transitional objects (Winnicott, 1953), childhood, nurturance, comfort, and self-soothing. The creation of sock monkeys or dolls may provide companionship, a loving object (Feen-Calligan et al., 2009), and opportunities for mirroring body image representations.

***Phase Two - Remembrance and Mourning***

This phase of treatment will promote the externalization, reflection, clarification, processing, and integration of emotional experiences central to experiences of AN through art-making and group discussion (Jeong & Kim, 2006; Murphy, 1984; Fleming, 1989). Emphasis will be placed on individual and collective sharing of experiences related to the development of maintenance of an ED, with a focus on family dynamics, attachment relationships, and emotional experiences to initiate the process of integration (Herman, 1992) and increase emotional connection to others (Tasca, 2019).

**Session 4A.** Participants will warm up using a *wet-on-wet watercolour* exercise (Makin, 2000b) to introduce spontaneity, loss of control, and unpredictability within a contained space using watercolour paper taped on the table to reduce anxieties (Proulx, 2003).

The main intervention will be a lifeline (Hinz, 2006; Pifalo, 2011) in the form of a *graphic lifeline* (Martin, 1997) or the *river of life drawing* (Denov & Schevell, 2021).

Participants will be asked to draw a continuous line or river to express their feelings in relation to major life events, milestones, and challenges throughout their lives, beginning with childhood and continuing to the present day. Lines may correspond to feelings about changes, for example, rising up or dipping down, increasing in intensity or variety (e.g. zig zags, curves, spirals, Martin, 1997) or with metaphors of the river including bridges, rocks, shelter, and storms (Denov & Schevell, 2021). Each important event or milestone should be identified with a drawn picture, word, or symbol. Participants will then be encouraged to look intentionally at their lifeline to reflect on when and how the ED is represented. Discussion questions include events leading up to the start of the ED, how the ED influenced other major events and milestones, and whether one was fully present at all of the events depicted. Participants will then be asked to extend the line to depict what they wish their life will look like in the next five years using the same drawing process to foster reflection, clarification, and integration of experiences.

**Session 4B.** A *paper-making* (Matott & Miller, 2023) skillshare led by the art therapist can be a cathartic and mindful experience for clients to engage on the sensory and kinesthetic levels of the ETC (Lusebrink & Hinz, 2022; Hinz, 2020) for nervous system regulation. The process itself may provide mastery through repetitive movements, unique results, and connection with natural aspects of papers and recycled materials.

**Session 5A.** Participants will be led through a brief *box breathing* (Young, 2021) exercise to practice intentional and mindful breathing while using watercolours to create a *visualization of the breath* (Feen-Calligan, 2020).

Participants will be instructed to create a *childhood family drawing* and an adapted kinetic family drawing for the main intervention, following Hinz's (2006) directives: "Draw a picture of your family at the time the eating disorder started. Be sure to include each family member and draw your family engaged in an activity" (p. 63). This intervention will aim to examine childhood influences of AN and spark discussion on family dynamics, functioning, support, attachment, and potential trauma within the family. As with the kinetic family drawing (Burns & Kaufman, 1970), the typical activities, along with the placement and size of figures may indicate power, relationships, and emotional closeness of clients' familial relationships. Discussion points may include family influences as predispositions for the development of AN, along with personal needs, the presence of emotional and physical boundaries, internalized messages and roles, and attachment styles within the family (Hinz, 2006).

**Session 5B.** The art therapist will provide a skillshare on *making play-dough* from scratch using flour, water, cream of tartar, table salt, vegetable oil, food colouring, and glitter for decoration. Essential oils can be added to introduce scents and enhance sensory stimulation (Hinz, 2020). Participants are invited to create their own play-dough to promote a soothing experience. They will then participate in a sensory and kinesthetic interaction (Proulx, 2003; Malchiodi, 2023; Hinz, 2020; Buchalter, 2009) by squeezing, kneading, rolling, pressing, dabbing, pinching, and tearing the dough through a lens of mindfulness while considering the sensory qualities: smell, hardness, softness, moisture, texture, and temperature. Participants may choose to create an object or shape if desired. Sensory engagement will promote affective experiences, the matching of internal and external experiences, mindful awareness, self and co-regulation, and moving away from cognitive levels of functioning that may be a barrier for clients with AN (Hinz, 2020; Hinz, 2006).

**Session 6A.** Adapted *scribble chase mirroring activity* (Lusebrink, 1990; Betts, 2008) in dyads will involve a "leader" and a "mirror" who then switch. The leader will scribble while the mirror follows on their own paper to re-enact the separation-individuation process and increase self-efficacy through attunement (Betts, 2008). A brief discussion will explore feelings of being the leader versus the follower, and the process of non-verbal communication and art-making (Betts, 2008).

The main intervention borrows from Betts' (2008) "*separation from the eating disorder*" intervention, where participants are asked to name their ED, with typical examples including "Satan", "Anna", "Ed", or "It." Separating a page in half, participants will create an image of their ED on one side, and on the other, they will create an image of their true self without the ED. On a separate sheet of paper, participants will create an environment that should be large enough to hold the two figures and two shelters for the figures. Next, participants will cut out both the ED and true self figures and place them in the environment to represent clients' current realities having to share their life with their ED, with the goal of moving farther away from the ED until the true self emerges. This art image may be used as a check-in for clients to use their picture to gauge their process, moving the ED and true self figure accordingly.

**Session 6B.** A skillshare on *needle felting* will provide participants with a meditative and soothing craft engaging on sensory and kinesthetic levels of the ETC (Hinz, 2020; Lusebrink & Hinz, 2022) through mindful and tactile creation. The repetitive and straightforward nature of

needle felting can provide participants with a sense of accomplishment, control, mastery, and self-efficacy. This arises from creating something meaningful through simple and meditative action. Tactile and sensory engagement may also result in the engagement of body and mind aspects of the self, serving as a distraction from anxiety, stress, and the other challenges of hospitalization (Czamanski-Cohen & Weihs, 2016). The task of transforming wool fibres into a compact and sculptured from repeatedly interconnecting the fibres may also reflect secure attachment bonds through its metaphor of a secure base for connection, stability, repair, and mending.

**Session 7A.** The warm-up will consist of a *collaborative small group sculpture*. Participants will be instructed to choose two colours of plasticine (approximately a grape-sized amount of both colours) to work with during the activity, with each colour of plasticine representing an emotion. Participants will then combine the two colours of plasticine together until they are mixed to become one colour while focusing on the sensory elements of the plasticine in their hands. This will represent emotions that may sometimes be mixed together and hard to disentangle (e.g. angry and sad). Individually, participants will create a small shape with their plasticine. Then, as a group, they will decide how to assemble these shapes into a small sculpture representing their collective and varied emotions and colours

For the *inside/outside self-box* intervention*,* clients will be provided with plain cardboard boxes with lids of various sizes. Before beginning, participants are asked to contemplate the similarities and differences between the inside and the outside of the box. They will then be asked to explore familial or social expectations about the private and public self. Building off of the inside/outside duality, participants also will be encouraged to explore how they are perceived on the outside versus how they feel on the inside, or what they show to others versus what they keep inside (Fleming, 1989; Hinz, 2006; Chu, 2010; Edwards, 2005; C. York, personal communication, January 31, 2024).

**Session 7B.** At this stage in therapy, the introduction of more fluid materials through a foundation of containment and safety will be encouraged to promote experimentation, exploration, agency, and mastery (Fleming, 1989; Hinz, 2020). *Splatter paintings* will encourage discussion on bodily experiences and engagement using embodied self-expression through a mind-body connection (Betts, 2008; Czamanski-Cohen & Weihs, 2016; Malchiodi, 2020). Clients will use washable tempera paints and large brushes to engage their bodies in throwing

paint onto large mural paper taped on the wall. Washable tempera paint will be important for this activity to reduce feelings of anxiety and provide containment of the mess. Aprons or labcoats will be provided if participants desire.

***Phase Three - Reconnection and Integration.***

The final phase of the group will focus on meaning-making, looking towards the future, and re-engagement with one's dreams and goals. Specifically, it will focus on clients developing a coherent narrative and sense of self, attachment relationships, increasing emotional connection with others (Tasca, 2019), and separating oneself from the ED.

**Session 8A.** The warm-up will consist of using washable markers with a variety of colours to write out anxieties, insecurities, fears, and/or challenges on *coffee filter*s. Participants will then use ink droppers filled with water to soak the coffee filters and watch as the words fade into each other to produce a mix of colours. If time permits, participants will then take another coffee filter to write down things they are grateful for including supports and strengths in their lives.

As outlined by Hinz (2006), participants are invited to create a *baby animal self* using open media to explore their physical and emotional needs while practicing self-nurturance. Discussion topics may revolve around the unique characteristics of different animals and what is required for the animal to grow strong and healthy (Hinz, 2006; Henderson, 1999), touching on the themes of nurturance, dependence, autonomy, individuating from the family, asking for help, and leaning on others for support. Reconnecting with our animal nature through therapeutic processes has been increasingly recognized as a valuable healing technique (Myers, 1998), and the ability to pretend to be an animal can aid in the development of social skills in human roles (Bédard-Gascon, 2014). This intervention will focus on themes surrounding inner child work and attachment (Mancewicz, 2013). A second part of the intervention if time permits may include dialoguing with one's baby animal.

**Session 8B.** The optional skillshare will consist of *gelli plate printing* with found objects and natural materials to promote self-efficacy, mastery, and experimentation.

**Session 9A.** Participants will collaborate with one another to fill the entire large paper-covered table with *bingo dabbers* for a modified creative mobilization technique (Liebmann, 2004). Each participant will be given two bingo dabbers to promote bilateral stimulation (Malchiodi, 2020) and kinesthetic engagement (Hinz, 2020) by dabbing on the table until the

white paper is all filled with colour. The art therapist will also encourage participants to “lead” by creating a beat or rhythm with their bingo dabbers and for other participants to “follow” to promote mirroring, attunement, and co-regulation.

As a closing group project, clients will be encouraged to create a personal symbol of recovery through drawing or painting, adapting the concepts of Drass' (2015) "Strength Medallions" and Buchalter's (2009) "Mural of Hope”. Clients are then invited to create a personal piece representing hopes and goals for recovery (Hays, 2021). Individual pieces will then be collaboratively “woven” together to create a *hopes and goals group quilt* incorporating each participant’s symbols, hopes, and goals while exploring the significance of self within the group and celebrating individual and collective strengths. The use of a collaborative project will aim to facilitate the normalization and validation of individual experiences within the group, as they allow for the exploration of how one client's story and experiences intersect with those of others (Matto, 1997). Participants who may have left the group due to discharge are asked to create their piece of the group quilt before they terminate. Their contribution will be added to the final group quilt. The quilt will help externalize the impact participants have had on each other throughout therapy, serving as a symbol of strength, self-esteem, acceptance, and progress that clients can take with them after termination (Hinz, 2006). A printed photograph of this group project will be provided to each client to take home with them.

**Session 9B.** The optional skillshare will introduce *paint pouring* using tempera paints as a process-based art-making activity to explore spontaneity and a mind-body connection (Betts, 2008; Czamanski-Cohen & Weihs, 2016; Malchiodi, 2020). At the end of the session, clients will be asked to share a song of their choosing to be used for the following week’s *painting to music* (Liebmann, 2004) warm-up.

**Session 10A.** The group will begin with a *painting to music* (Liebmann, 2004) warm-up, with the art therapist playing 1 minute of each participant’s chosen song. Participants will be encouraged to work kinesthetically, using their whole body to engage in art-making and the rhythm of the music.

For the main intervention, participants will be asked to represent themselves as a *developing seed* to reflect on where they are at now and what their future goals encompass (Betts, 2008). They will then create a *self-garden* that represents the environment for this seed to grow in (Guzman, 2020). Discussion themes will include gains in therapy through the

representation of foundational skills, relationships, and aspects in the garden (e.g. soil, roots, people in the garden), future goals for growth, and ways to nourish, tend, and maintain the garden through coping strategies and resources (e.g. rain, sun, water).

**Session 10B.** For the last open studio session, the art therapist will provide a skillshare on how to make *stickers* with clear tape and wax paper so that participants can exchange small tokens with other participants as the group concludes. Participants will create small images or cut out images from magazines. With a sheet of wax paper, participants will lay down clear tape in strips and place their image on top of the clear tape, with the image facing upwards. Next, participants will place another layer of clear tape to seal or laminate the image. They will cut around the image and peel the wax paper off the back to create their own stickers. Participants will be able to exchange stickers with other group members or create small cards for other group members with their stickers if desired. Time will be allocated at the end of the session for an optional portfolio review as a group. The session will close with the *magical box* ritual (Johnson, 1968). The art therapist will lead the group members to imagine a magical box that can hold anything participants wish for it to hold, while providing anything they wish to take with them. Going around the circle, all participants will first share something they would like the box and group to contain for them. A second round will encourage participants to share something they wish to take away from the box and the experience of the group.

## Chapter 6. Conclusion

This theoretical intervention research paper examined interdisciplinary data encompassing peer-reviewed, non-peer-reviewed, theoretical, and practice-based literature along with grey literature sources. The synthesis of these findings explores the integration of trauma-informed and attachment-focused AT in addressing attachment needs and treatment goals of adolescents with AN in PHP contexts. Given the outlined problem theories that encompass insecure attachment, relational and attachment traumas, and emotional dysregulation, the development of a trauma-informed and attachment-focused AT group intervention within a PHP setting may contribute to efforts and responses to the prevalence of ED and challenges to ED treatment by addressing specific gaps that other treatments may not touch on. With AT's unique experiential and non-verbal qualities, this paper summarizes how AT can be beneficial in addressing trauma and attachment wounds in the context of AN while outlining a potential plan for its implementation with this population.

Through the intervention design process, introduction of various models of trauma-informed AT interventions are outlined with the aim of bridging the gaps between theoretical findings and practice-based findings. This paper provides avenues for further study and integration of AT into multimodal treatment and gaps it may fill. Resulting findings conclude with a proposed intervention plan informed by literature examined in this paper.

Revisiting the initial research questions, a trauma-informed AT group may be designed to support this population through the intersection of modern attachment theories and neuroscience-informed AT models such as the ETC (Hinz, 2020; Lusebrink & Hinz, 2022), ATR-N (Hass-Cohen & Findlay, 2015), and the Bodymind (Czamanski-Cohen & Weihs, 2016) model to bridge gaps between primarily psychodynamic theoretical findings in the field combined with current treatment needs (Tasca, 2019). Secondly, a trauma-informed group may be conceptualized through a directive and non-directive approach, combining traditional clinical group AT structures and an open studio structure to address proposed goals. Finally, best practices for the integration of AT within the multimodal team are outlined in the program structures and processes through the identification of the role of the art therapist, therapeutic engagement, use of art materials, importance of confidentiality, and considerations with using directives.

Proposed interventions and timing of interventions are specifically designed according to Herman's (1992) phase-based model of trauma-informed care. Careful considerations of media and projects aimed to promote a secure base for positive attachments with others through the group dynamic, co-regulation with peers, and safety of the contained art studio. This is outlined through the choice of media informed by the ETC (Hinz, 2020; Lusebrink & Hinz, 2022), moving from more predictable and controlled materials to fluid and affective ones, with the aim of promoting spontaneity while reinforcing containment and regulation. Proposed interventions also serve a two-fold purpose: clarifying emotional experiences relating to the development and maintenance of AN, while promoting earned secure attachments in the process.

**Recommendations**

Given the delimitations of this study as outlined in earlier sections, future implementation of this proposed intervention plan may be the logical next step for future directions to test efficacy and examine intermediate and distal outcomes of program outputs. On another hand, in consideration of contemporary approaches to ED treatment, integration of health at every size (HAAES), anti-oppressive approaches, anti-fat bias, harm reduction, body liberation, weight-

inclusive, and queer-affirming approaches should be explored further to consider the diverse presentations of EDs.

Consideration of the art therapist's stance and attunement in supporting the idea of the client's play, exploration, creation, and mess may also be further explored to examine how to best therapeutically engage this population in experiential modalities. This may even be addressed in further research on client's perceptions and experiences of therapy. As Edwards (2005) describes, client voices to treatment are often "an ominous silence" (p. 97) in the field of AT literature, with a majority of literature biased towards the views of the therapist or researcher rather than the client. Input and implementation of the voices of clients may prove to be beneficial in future research (Edwards, 2005), for example, through patient and family advisory research committees or leadership programs (M. Harrison, personal communication, January 19, 2024). Such implementation will help promote holistic, non-hierarchical, and anti-oppressive research practices and topics based on clients and their families' needs and perspectives.

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# Appendix A: Literature Review Tables

## Table A1

Summary and characteristics of practice-based peer-reviewed studies.

| Author(s) and Date | Title | Study Design | Population | Interventions | Goals of Interventions | Therapeutic Modality | Facilitator(s) | Concurrent Therapies |
|---|---|---|---|---|---|---|---|---|
| Acharya et al., (1995) | What Can the Art of Anorexia Patients Tell Us About Their Internal World: A Case Study | Case study | Adult (27) | Group AT once a week for 15 months | N/A | Psychodynamic | Art therapist (second author, Michele J. M. Wood) | Inpatient treatment |
| Brockmeyer, et al. (2021) | Cognitive remediation therapy in anorexia nervosa-A randomized clinical trial | RCT | Adults and adolescents | Cognitive remediation therapy and AT (100 minutes in group format); AT did not focus directly on symptoms; both CRT and AT were manualized (not specified) | Promote expression and processing of feelings through art, involving themes of identity, social interaction, future, resources | N/A | 2 qualified art therapists with 2 years of experience in the treatment of AN | None |
| Diamond-Raab & Orrell-Valente (2002) | Art therapy, psychodrama, and verbal therapy. An integrative model of group therapy in the treatment of adolescents with anorexia nervosa and bulimia nervosa | Case study | Adolescents (12, 16) | AT for less than a month | N/A | N/A | Art therapist (first author, Lisa Diamond-Raab) | Individual therapy, family therapy |
| Eren et al., 2023) | Effect of a long-term art-based group therapy with eating disorders | Pre-test post-test, quasi-experimental study with a control group | Adolescents and adults (18-55) | 30-week long-term semi structured art-based group therapy (120 minutes, once a week) | N/A | N/A | Clinical psychologist and visual arts instructor (completed an art psychotherapy certificate program) | Standard treatment at an outpatient center |
| Griffin et al. (2023) | Art therapy and eating disorders: A mixed methods feasibility study | Mixed-methods feasibility study; repeated measures design | Adults | Group AT twice a week for 1.5 hours over 15 sessions (the only aspect of the program that was voluntary); Session A and Session B | Maximize self-determination, self-management, choice, positive risk-taking | Person-centered, recovery-oriented | Art therapist (first author, Caryn Griffin) | 8-week Day Patient Program (nutritional support, psychology, social work, ward rounds) |
| Guez et al. (2010) | Self-figure drawings in women with anorexia; bulimia; overweight; and normal weight: A possible tool for assessment | Multiple regression analysis | Adult women | AT assessment | N/A | N/A | N/A | None |

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| Jeong & Kim (2006) | Art therapy: Another tool for the treatment of anorexia nervosa | Case study | Adolescent (15) | Weekly AT combined with other multimodal approaches (2 months) | Promote catharsis, externalization, reflect and clarify challenges central to ED | N/A | Art therapist (first author, Hae-Young Jeong) | Outpatient treatment |
| Johnson & Parkinson (1999) | There's No Point Raging on Your Own: Using Art Therapy in Groups for People with Eating Disorders | N/A | N/A | Weekly AT for 1.5 hours over a 9-month period | Moving from relating to one's art-making to being able to relate to others | N/A | Art therapists (both authors) | N/A |
| Kessler (1994) | A Study of the Diagnostic Drawing Series with Eating Disordered Patients | Descriptive research method | Adults and adolescents (15-54) | Group and individual AT | N/A | N/A | N/A | Unspecified treatment facility |
| Ki (2011) | Exploring the Experiences of Participants in Short-term Art-Based Support Groups for Adults Living with Eating Disorders | Qualitative study: narrative approach | Adult women | 3 art-based support group sessions at a non-clinical ED support center | N/A | N/A | Art therapist (author, student at the time) | None |
| Lock et al. (2017) | Feasibility Study Combining Art Therapy or Cognitive Remediation Therapy with Family-based Treatment for Adolescent Anorexia Nervosa | RCT | Adolescents (12-18) | 15 sessions of family-based therapy with 1) cognitive remediation therapy, or 2) AT; manualized AT; 30 minutes of AT prior to each of the 15 family-based therapy sessions | Encouraging metacognition by thinking about one's production with an emphasis on emotional expression and understanding | N/A | N/A | Family-based therapy |
| Makin (1994) | Art Therapy on an Inpatient Eating Disorders Program | Case study | Adult (24) | Individual AT for 6 sessions over 5 weeks | N/A | N/A | Art therapist intern (author) | Inpatient ED treatment |
| Shaw (2020) | 'Don't look!' An online art therapy group for adolescents with Anorexia Nervosa | Case vignette | Adolescents (12-17) | Online group AT for 1 hour over 7 weeks | N/A | Psychoanalytic, systemic, self-psychology | Art therapist (author) and clinical nurse specialist | Outpatient ED treatment |
| Thaler et al. (2017). | An adjunctive, museum-based art therapy experience in the treatment of women with severe eating disorders | Thematic analysis, quantitative analysis | Adults | 13 museum AT sessions consisting of: lunch, a guided tour of the museum (1-1.5 hours), and art-making (total time: 4.5 hours) | Promoting discovery of art in a non-threatening environment, allowing participants to interact with and share observations about presented works of art, create art of their own | N/A | Certified art therapist | Day program treatment: psychotherapy (psychoeducational, cognitive behavioural therapy, interpersonal, dialectical behavioural therapy ) |

**Table A2**

Summary of non-practice-based peer-reviewed studies.

| Author(s) and Date | Title |
|---|---|
| Bettin et al. (2023) | Visual art- and music-based interventions as adjuvants in the treatment of eating disorders: a systematic review and a theoretical model |
| Bucharová et al. (2020) | Arts Therapies Interventions and Their Outcomes in the Treatment of Eating Disorders: Scoping Review Protocol |
| Frisch et al. (2006) | Arts-Based Therapies in the Treatment of Eating Disorders |
| Griffin et al. (2021) | Effectiveness of art therapy for people with eating disorders: A mixed methods systematic review |
| Holmqvist & Persson (2012) | Is there evidence for the use of art therapy in treatment of psychosomatic disorders, eating disorders and crisis? A comparative study of two different systems for evaluation |
| Matto (1997) | An Integrative Approach to the Treatment of Women with Eating Disorders |
| Misluk-Gervase (2021) | Art Therapy and the Malnourished Brain: The Development of the Nourishment Framework |
| Prijatna et al. (2021) | The Use of Art Therapy in the Treatment of Eating Disorders: A Systematic Review |
| Rehavia-Hanauer, 2003 | Identifying conflicts of anorexia nervosa as manifested in the art therapy process |
| Schaverien (1989) | Transference and the picture: Art therapy in the treatment of anorexia |
| Schaverien (1994b) | The Transactional Object: Art Psychotherapy in the Treatment of Anorexia |
| Sporild & Bonsaksen (2015) | Therapeutic factors in expressive art therapy for persons with eating disorders |
| Ticen, 2013 | Feed me … Cleanse me … Sexual Trauma Projected in the Art of Bulimics |

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| Wood (1996) | Art therapy and eating disorders: theory and practice in Britain |

## Table A3

Summary and characteristics of practice-based grey literature.

| Author(s) and Date | Title | Study Design | Population | Interventions | Goals of Interventions | Therapeutic Modality | Facilitator(s) | Concurrent Therapies |
|---|---|---|---|---|---|---|---|---|
| Beck (2007) | Art Therapy with an Eating Disordered Male Population: A Case Study | Case study | Adolescents and adults (18-60) | Weekly AT, BATES assessment (draw two people doing something in a place), | N/A | Psychodynamic | Art therapy intern (author) | Inpatient treatment: group therapy, family therapy, individual therapy |
| Brown (2019) | Increasing self-esteem in adult women through a group art therapy and media literacy approach | Mixed-methods study | Adults (26-65) | Group AT using media literacy once a week for 2 hours over 5 consecutive weeks: body image visual journaling, viewing of videos on media manipulation of body image | Increase self-esteem | Narrative, person-centered | Art therapy intern (author) | None |
| Chaves (2011) | The creation of art books with adolescents diagnosed with eating disorders: Effectiveness, self-esteem, and related factors | Quasi-experimental | Adolescents and adults (12-21) | Group AT once a week for 3.5 hours; therapeutic art book | Improving self-esteem | N/A | Art therapy intern (author) | Inpatient or PHP treatment |
| Cooke (1999) | Art Therapy as Treatment for Anorexia Nervosa in Adolescents: A Case Study | Case study | Adolescents | Group art book session (3.5 hours) once a week: creation of individual art books using collage and drawing | N/A | Psychodynamic | Art therapy intern (author) | Inpatient and outpatient treatment |
| Edwards (2005) | I just want to melt away: 'treatment' of women with eating issues: a critical feminist informed view of art therapy and the exploration of an alternative approach. | Dual case study | Adults (early 20s, late 30s) | Group AT for 10 sessions; badges, round-robin drawings, sand tray figurines, journals, collage, self-portrait as an animal in a safe place and an unsafe place, image of the inner critic | Exploring identity, power, safety, the inner critic, externalizing eating issues, and identifying wants and needs. | Feminist | Art therapy intern (author) and social worker | Outpatient treatment |
| Good & Davis-Hubler (2019) | Art Therapy: Images of Recovery | Case study | Adolescent (15) | Client-centred and directed, with art responses for the following: “What would your life look like without your ED?”, What does life look like with your ED?”, “What would it look like to confront your ED?”, “What does recovery look like?” | Externalizing thoughts, feelings, conflicts, behaviours | Trauma-informed, client-centred | N/A | Outpatient treatment |
| Harnden (1995) | Starving for expression inside the secret theatre: an art and drama therapy group with individuals suffering from eating disorders | Case studies | Adults (18, 19, 26) | Group drama therapy and AT for 8 weeks (self-box, mask, past/present/future drawing) | Exploring separation and individuation | Psychoanalytic | Drama therapist intern (author) | Hospitalization (unspecified program) |
| Hays (2021) | Exploring Art Therapy with Clients Suffering from Eating Disorders in an Out-Patient Setting | Case studies | Adults | Drop-in virtual group AT for 1 hour over 4 weeks: coping skills toolbox, inner and outer box or collage, 3D safety corner, hopes and goals for | Explore inner and lived experiences, and practice skills to navigate the holiday season | N/A | Art therapy intern (author) and social work intern | Outpatient |

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| | | | | recovery collage | | | | |
| Mann (2023) | Using Plaster Castings of the Body as an Art Therapy Intervention to Explore Embodiment in Individuals with Eating Disorders | Case studies | Adults | Two hour-long individual AT sessions: plaster cast of a body part and transformation into expressive sculpture | Explore embodiment, improve self-concept | N/A | Art therapy intern (author) | N/A |
| Newman (2004) | Taking Focus: A Case Study of Photography Used in an Art Therapy Group for Adolescent Girls Diagnosed with Anorexia Nervosa | Case study | Adolescents (12-17) | Group AT for 10 sessions over 5 weeks using photography: self-portrait, collage, photo collage book, group mural, portfolio personalization, | Create an emotionally, psychologically, and physically safe environment for the expression of emotions; offer new coping strategies for self-empowerment, growth, and healing; for patients to take an active role in their treatment | Humanistic and person-centered | Art therapy intern (author) | Outpatient and inpatient |

**Table A4**

Summary of non-practice grey literature.

| Author(s) and Date | Format | Title |
|---|---|---|
| Alati (2019) | Master's research project | A Theoretical Exploration of Feminist Perspectives and Art Therapy for Body Image Issues in Adolescent Females |
| Andersen (2008) | Book chapter | The Body Outline Drawing Technique: Clinical Considerations for Eating Disordered Trauma Survivors |
| Betts (2008) | Book chapter | Art Therapy Approaches to Working with People Who Have Eating Disorders |
| Brooke (2008) | Book | The Creative Arts Therapies and Eating Disorders |
| Brun (2006) | Master's research project | Anorexia Nervosa in Adolescence: An Exploration of the Personal Unconscious in Art Therapy |
| Butryn (2008) | Master's research project | Art Therapy and Eating Disorders: Introducing Feminist Post-Structuralist Perspectives |
| Cameron & Kipnis (2015) | Book chapter | Making Sense Through Creativity: Creative Arts Therapy with Adolescents in an Inpatient Eating Disorder Program |
| Clark (2015) | Book chapter | DBT in Action: Integrating Art Therapy Techniques and Dialectical Behavior Therapy Skills Training in the Treatment of Eating Disorders |
| Clark (2021) | Book chapter | DBT in Action: Art Therapy and DBT Skills Training in Treating Eating Disorders |
| Dean (2008) | Book chapter | Preserving the Self: Treating Eating Disorders Individuals Who Self-Injure with Art Therapy |
| Dean (2013) | Book chapter | Cultural Considerations of Eating Disorders through Art Therapy |
| Dokter (1994) | Book | Arts therapies and clients with eating disorders: Fragile board |

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| Edwards (2008) | Book chapter | Bringing “The World” into the Room: Art Therapy, Women and Eating Issues |
| Fleming (1989) | Book chapter | Art Therapy and Anorexia: Experiencing the Authentic Self |
| Gray (1997) | Master’s thesis | The mirror within: An art therapy research project identifying the links between anorexia nervosa, object relations and the potential role of art as the transitional object |
| Heiderscheit (2015) | Book | Creative Arts Therapies and Clients with Eating Disorders |
| Hinz (2006) | Book | Drawing from Within: Using Art to Treat Eating Disorders |
| Hornyak & Baker (1989) | Book | Experiential Therapies for Eating Disorders |
| Horrex (1999) | Master’s thesis | Art and body image: A journey through anorexia nervosa and the implications for art therapy rituals |
| Hunter (2012) | Book | Reflections of Body Image in Art Therapy: Exploring Self Through Metaphor and Multi-Media |
| Hunter (2016) | Book chapter | Art Therapy and Eating Disorders |
| Marmor (2015) | Book chapter | Body and Self: The Use of Art Therapy in Eating Disorder Treatment |
| Levens (1995) | Book | Eating Disorders and Magical Control of the Body: Treatment through Art Therapy |
| Luzzatto (1994) | Book chapter | Art Therapy and Anorexia: The Mental Double Trap of the Anorexic Patient: The Use of Art Therapy to Facilitate Psychic Change |
| Mackenzie (2011) | Master’s research project | An Evolutionary Perspective on Anorexia Nervosa: Theoretical Explorations of Applications for Art Therapy |

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|---|---|---|
| Makin (2000) | Book | The Art of Eating Disorders |
| Morenoff & Sobol (1989) | Book chapter | Art Therapy in the Long-Term Psychodynamic Treatment of Bulimic Women |
| Murphy (1984) | Book chapter | The use of art therapy in the treatment of anorexia nervosa |
| Rabin (2003) | Book | Art Therapy and Eating Disorders: The Self as Significant Form |
| Rust (1992) | Book chapter | Art therapy in the treatment of women with eating disorders |
| Schaverien (1994a) | Book chapter | The Picture as a Transactional Object in the Treatment of Anorexia |
| Wood (2000) | Book chapter | Making a mark: An exploration of an art therapy group for clients with eating disorders |

**Table A5**

An outline of relationships between the research question and studies that fit inclusion/exclusion criteria for program theories but do not focus on ED populations.

| **Author(s) and Date** | **Relation to Current Study and Research Question** | | | |
|---|---|---|---|---|
| | Trauma-Informed | Attachment-Focused | Mind-Body | Adolescent Population |
| Czamanski-Cohen & Weihs (2023) | ✓ | ✓ | ✓ | |
| Feen-Calligan et al. (2020) | ✓ | | | ✓ |
| Kelemen & Shamri-Zeevi (2022) | | | | ✓ |
| Luzzatto et al. (2022) | ✓ | | | |
| Sitzer & Stockwell (2015) | | | | ✓ |
| Strouse et al. (2021) | ✓ | | | |

## Appendix B: Goals and Sessions Overview

**Table B1**

Group goals and objectives.

| Group Goal | Objectives |
|---|---|
| 1. Experience a safe holding environment for healthy relationships and attachments through group dynamics and attunement with peers and therapist to promote a sense of earned secure attachment through rupture and repair (Schore, 2001; Findlay et al., 2008; Schore & Schore, 2008), non-verbal communication, co-regulation (Schore & Schore, 2008), and expression. | a. Foster and co-create a trusting, supportive, non-judgmental, and safe group atmosphere<br><br>b. Promote emotional expression and exploration through self and co-regulation |
| 2. Externalization, reflection, expression, clarification, processing, and integration of emotional experiences central to AN through art-making and group discussion (Jeong & Kim, 2006; Murphy, 1984, Fleming, 1989) | a. Identify and externalize emotional experiences<br><br>b. Foster reflection, clarification, and integration of emotional experiences through group discussion |
| 3. Foster a sense of control and agency over their recovery through decision-making within the group and art-making to promote integration | a. Empower individuals through collaborative decision-making<br><br>b. Promote autonomy, agency, self-efficacy, and mastery through art-making |

**Table B2**

Sessions overview table.

| Week | Session | Phase | Group Goals | Malleable Mediators | Interventions | Materials |
|---|---|---|---|---|---|---|
| 1 | A | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1a, 3a, 3b | Communication; boundaries; problem-solving skills; community belonging; interpersonal communication; attunement | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-group guidelines (Liebmann, 2004; Moon, 2016)<br>-warm-up: scribble drawing (Hinz, 2006)<br>-contained safe space collage (Czamanski-Cohen & Weihs, 2023; Sitzer & Stockwell, 2015; Schouten et al., 2018; Jones et al., 2018; Fleming, 1989)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -group guidelines: large paper, markers<br>-sign-in/sign-out wall and warm-up: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-safe space collage: magazines, scrapbook paper, scissors, book pages, glue, etc. |
| 1 | B | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: "playing" with different art materials (Hinz, 2020, Hinz, 2006; Lusebrink & Hinz, 2022; Graves-Alcorn & Kagin, 2017; Czamanski-Cohen & Weihs, 2023)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: watercolour, tempera paint, acrylic paint, finger paint, chalk pastels, oil pastels, markers, crayons, graphite sticks, tempera paint sticks, pencils, collage, colour pencils, clay, plasticine, found objects, string, straws, inks, fabrics, glue, scissors, sponges, ink pads, etc. |
| 2 | A | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1a, 1b, 2a, 2b | Communication; boundaries; problem-solving skills; community belonging | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: round-robin drawings (Liebmann, 2004; Edwards, 2005)<br>-collective group pie (Smallwood, 2019)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall and warm-up: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-collective group pie: Bristol board paper, markers, pencil crayons, pencils, pastels) |

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| 2 | B | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: shaving cream paint marbling<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: shaving cream, wooden skewers, acrylic paints, cardstock, plastic tray |
| 3 | A | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1a, 1b, 2a, 2b, 3a, 3b | Communication; boundaries; problem-solving skills; community belonging; interpersonal communication; capacity to lean on others for support; emotional connection with others; attunement; co-regulation; awareness, acceptance, integration, and processing of emotions | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: dyadic nonverbal communication (Graves-Alcorn & Kagin, p. 53)<br>-altered comfort books (C. York, personal communication, January 31, 2024; Chilton, 2007; Chaves, 2011)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall and warm-up: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-comfort books: hardcover used books, glue, tape, drawing materials, found objects, postcards, images, patterned papers, words, wallpapers, magazine clippings, maps, and textiles |
| 3 | B | Phase 1: Safety and Stabilization and Overcoming Dysregulation | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: sock monkeys/doll-making (C. York, personal communication, January 31; Feen-Calligan et al., 2009; Strouse et al., 2021)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: fabric, socks, sewing materials, scissors, buttons, yarn, other textiles |
| 4 | A | Phase 2: Remembrance and Mourning | 1b, 2a, 2b | Communication; boundaries; emotional connection with others; aility for trust and vulnerability in relationships; awareness, acceptance, integration, and processing of emotions | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: wet-on-wet watercolour (Makin, 2000)<br>-lifeline (Hinz, 2006; Pifalo, 2011)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: watercolour, watercolour paper, paintbrushes, water, sponges, droppers, tape<br>-lifeline: drawing, painting, and collage materials |
| 4 | B | Phase 2: Remembrance and Mourning | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: paper making<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: scrap papers, recycled papers, mould and deckle, towels, plastic storage tub, water, blender, sponge |
| 5 | A | Phase 2: Remembrance and Mourning | 1b, 2a, 2b | Capacity to lean on others for support; emotional connection with others; the ability for trust and vulnerability in | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: breath drawing (Feen-Calligan, 2020)<br>-childhood family drawing (Hinz, 2006) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: watercolour paints, paintbrushes<br>-childhood family drawing: drawing, |

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| | | | | relationships; wareness, acceptance, integration, and processing of emotions | -taking away/leaving behind<br>-sign-out wall (Riley, 1999) | painting, and collage materials |
| 5 | B | Phase 2: Remembrance and Mourning | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: play-dough making and sensory interaction (Proulx, 2003, p. 79; Malchiodi, 2023; Hinz, 2020; Buchalter, 2009) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: flour, water, cream of tartar, table salt, food colouring, vegetable oil, glitter, essential oils, modeling tools, cookie cutters |
| 6 | A | Phase 2: Remembrance and Mourning | 1a, 1b, 2a, 2b | Capacity to lean on others for support; emotional connection with others; the ability for trust and vulnerability in relationships; wareness, acceptance, integration, and processing of emotions | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: scribble chase (Lusebrink, 1990)<br>-separation from the eating disorder (Betts, 2008; Good & Davis-Hubler, 2019)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall and warm-up: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-separation from the eating disorder: drawing, painting, and collage materials |
| 6 | B | Phase 2: Remembrance and Mourning | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: needle felting<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: wool roving, felting pad, safety cushion or finger pads, felting needles |
| 7 | A | Phase 2: Remembrance and Mourning | 2a, 2b, 3a | Communication; boundaries; emotional connection with others; ability for trust and vulnerability in relationships; awareness, acceptance, integration, and processing of emotions | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: plasticine mixing and group sculpture<br>-inside/outside self-box (Fleming, 1989, Hinz, 2006; Chu, 2010; Edwards, 2005; C. York, personal communication, January 31, 2024)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: various colours of plasticine<br>-self-box: cardboard boxes of various sizes with lids, access to all materials in the art room, found objects |
| 7 | B | Phase 2: Remembrance and Mourning | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: splatter paintings (Betts, 2008)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: large mural paper, aprons or lab coats, washable tempera paints, large paintbrushes |

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| 8 | A | Phase 3: Reconnection and Integration | 2a, 2b, 3b | Communication; boundaries; emotional connection with others; ability for trust and vulnerability in relationships; awareness, acceptance, integration, and processing of emotions; self-regulation | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: coffee filters<br>-baby animal self (Hinz, 2006)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: coffee filters, ink droppers, water, washable markers<br>-baby animal self: needle felting supplies, felt, textiles, boxes, Altoid tins, sewing materials, mixed media, plasticine, air dry clay, painting materials |
| 8 | B | Phase 3: Reconnection and Integration | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: gelli plate printing<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: gelli plates, inks, paints, found objects, natural materials (leaves, branches, sticks, flowers) |
| 9 | A | Phase 3: Reconnection and Integration | 1a, 1b, 2a, 2b, 3a, 3b | Communication; boundaries, quality and availability of social networks; community belonging; interpersonal communication and conflict resolution skills; capacity to lean on others for support; emotional connection with others; ability for trust and vulnerability in relationships; predictable and consistency of environment and relationships; effective rupture and repair; integration and processing of emotions; co-regulation | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm-up: group bingo dabbers<br>-group quilt: hopes and goals for recovery (Hays, 2021)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: bingo dabbers, two for each participant<br>-group quilt: painting, drawing, and collage materials |
| 9 | B | Phase 3: Reconnection and Integration | 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: paint pouring<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: canvas boards, tempera paints, water |

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| 10 | A | Phase 3: Reconnection and Integration | 1a, 1b, 2a, 2b, 3a, 3b | Communication; boundaries, quality and availability of social networks; community belonging; interpersonal communication and conflict resolution skills; capacity to lean on others for support; emotional connection with others; ability for trust and vulnerability in relationships; predictable and consistency of environment and relationships; effective rupture and repair; integration and processing of emotions; co-regulation | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-warm up: painting to music (Liebmann, 2004)<br>-assembling group quilt (Hays, 2021)<br>-self as a developing seed (Betts, 2008) and self-care garden (Guzman, 2020)<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-warm-up: painting materials (watercolour, tempera, acrylic, paintbrushes)<br>-self as a developing seed and self-care garden: painting, drawing, and collage materials, textiles, found objects, natural materials, |
| 10 | B | Phase 3: Reconnection and Integration | 1a, 1b, 3a, 3b | Boundaries, self-regulation; co-regulation; attunement; predictability and consistency of environment and relationships | -sign-in wall (Riley, 1999)<br>-roses, thorns, buds<br>-open studio<br>-optional skillshare: stickers<br>-portfolio review (Czamanski-Cohen & Weihs, 2023<br>-taking away/leaving behind<br>-sign-out wall (Riley, 1999) | -sign-in/sign-out wall: markers, pencils, pencil crayons, oil pastels, soft pastels<br>-open studio: access to all materials in the art room<br>-optional skillshare: wax paper, paper, drawing materials, clear tape, collage |