What Do We Mean By Support?

A Discourse Analytic Study of Practitioners' Talk about Facilitating Support Groups for Eating and Body Image Issues

Patricia Hoi Ling Ki

York University

Faculty Advisor: Dr. Susan McGrath

A practice-based research paper submitted to

the School of Social Work of York University in partial fulfillment of

the requirements for the degree of Master of Social Work

2014

Table of Contents

Chapter 2: Review of Literature

Chapter 3: Research Design

Chapter 5: Discussion and Conclusions

Figures

Appendices

Acknowledgements

I am indebted to the practitioners who generously and openly shared with me their experiences, successes, and challenges in their work. Their commitment and enthusiasm for the continual improvement of support and resources for people living with eating and body image issues are what made this research possible. I am thankful for Dr. Susan McGrath, whose guidance, patience, flexibility, and strong belief in her students made this seemingly insurmountable task doable. I thank also my professors, Harjeet Badwall, Chris Chapman, and Renita Wong, whose teachings about the discursive construction of goodness, the ethics of asking what is important to people rather than what is wrong with people, and the necessity of taking a stance give this research its foundation. I am always grateful for my mentor, Suzanne Thomson; her imaginative and collaborative practice approaches, grounded in a fierce commitment to social justice, are a testament that social transformation and resistance to subjugation can be achieved through everyday, local practices of support. And I cannot ever thank my family and friends enough; their unwavering love and support through my various struggles with food and with my self are the reasons I am still here today, doing this work.

Abstract

The purpose of this research is concerned with the ways service providers define, construct, and understand their practices and approaches in facilitating support groups in community-based settings for adults living with eating and body image issues. It aims to identify the discourses and power relations that both give shape to and are continually shaped by facilitators' understanding and practices. Critical feminist analyses have found that psycho-medical treatment models for 'eating disorders' often paradoxically reinforce the gendered discourses and discursive practices that constitute eating and body image issues in the first place. Examining the ways that group facilitators understand and define their practices through a critical feminist perspective and discourse analytic framework opens up new possibilities in practices of support to disrupt the discourses and power relations that contribute to eating and body image problems. The findings of this study suggest that psycho-medical, humanist, and gender discourses are dominant in participants' constructions of their practices of support. Particularly, individualized understandings about eating and body image issues are reproduced. At the same time, individualizing and psychologising ideas are also challenged and resisted, especially in the ways participants question social and cultural norms and contemporary treatment methods when describing their understandings of support. The participants' practice contexts outside of medical institutions may position them as having less expertise in relations to those afforded higher statuses within discourses of medicine and psychiatry, yet their discursive positions also seem to allow space for alternative ways of working.

Chapter 1: Introduction

This study is born out of my past experiences of eating and body image problems and various forms of hospital and community-based interventions. It is born out of a deep concern that many people who have received mainstream ‘eating disorder’ treatment continue to experience a significant level of distress, and some eventually lose their lives to suicide or complications related to eating difficulties (American Psychiatric Association [APA], 2013; Malson, Bailey, Clarke, Treasure, Anderson & Kohn, 2011). It is born out of a sense of frustration that poor treatment outcomes are frequently attributed to service users (Hepworth, 1999; Guilfoyle, 2001; Malson et al., 2011; Moulding, 2006), yet the treatment methods, clinical practices, and their underlying assumptions are often left unquestioned (Malson et al., 2011). In recent years I have also taken up the role of a group facilitator, working with people dealing with eating difficulties. This study is therefore born out of a sense of urgency that honest, critical reflections are needed to examine professional practices in both hospital and community-based settings, so that we as service providers may avoid prolonging the distress of those who come to seek our support.

Focusing on how discourses constitute eating and body image issues and their interventions does not mean that I see people’s physical suffering and emotional distress as mere constructions with no basis in material realities. As Gremillion (2003) writes, “Constructionism does not preclude attention to bodily ‘reality.’ I take seriously the lived, material realities of both anorexia and biomedical practice, and I argue that these realities cannot be explained adequately in biomedical terms” (p. 33). I therefore take a firm stance in refusing to see eating and body image problems as merely issues of individual psychopathology, biological disturbances, or family dysfunctions. Though I recognize that biological or family issues may play a part in eating and body image problems, I believe that these problems and the ways that we have come to understand them are shaped by historically situated discourses, social practices, and power relations that are specifically related to gender (Bordo, 1993; Gremillion, 2003; Hepworth, 1999; Saukko, 2009). Detailed discussions about the etiology of eating and body image issues are beyond the scope of this paper; however, I do recognize that it is impossible to talk about support without discussing how we might address the different variables that contribute to eating and body image issues in practice. As such, in my critical review of literature and data analysis I examine the ways through which practice approaches are shaped by different understandings of how eating and body image problems develop. My belief echoes that of Hepworth (1999), who argues that support services that do not take into account the social and cultural contexts that are implicated in eating and body image issues risk reproducing the social conditions that give shape to these issues in the first place, and may therefore be limited in their usefulness or may even be counter-productive.

Yet, I do not advocate doing away with psycho-medical interventions entirely. I believe that medical interventions and psychotherapy can be very helpful and sometimes necessary in attending to people’s physical and emotional well-being (Gremillion, 2003; Guilfoyle, 2001). I am inspired by Michael White’s (2001) approach to narratives in that the purpose of deconstructing and analyzing stories is not about determining which stories are more “true” or “real” (p. 21) than others, but it is about understanding “the constitutive or shaping effects of all stories” (ibid.), while recognizing that “some stories sponsor a broader range of options for action in life than do others” (ibid.). As such, the purpose of this study is not to evaluate the effectiveness of support groups and the facilitators’ practices. Rather, I am curious about what facilitating support means to practitioners, what facilitators mean when they say that their approaches work or do not work, and “[what] are the politics of personhood that support these views” (Gremillion, 2003, p. 23). Understanding that research and report-writing are also discursive practices that produce knowledge about people, in this study I keep away from using the terms ‘eating disorders’ and other diagnostic labels to avoid furthering stories that pathologize (Weber, Davis & McPhie, 2006), except in instances where these terms are part of the concepts under discussion.

To a limited extent this research is informed by my previous study on participants' experiences of arts-based support groups, in which the research participants have identified community-based agencies as significantly more accessible than institution-based treatment and private therapy in terms of wait time and cost (Ki, 2011). Based on this finding and my own observations as a group facilitator in a community-based agency, I have suggested that support groups are an important area of study, as they can serve as alternative options for individuals who are waiting for treatment, choosing not to use institutional-based treatment, or looking for continual support after intensive treatment (ibid.). However, through a Foucauldian understanding of power and discourse (Healy, 2000), community-based support groups can also be viewed as local sites where dominant, subjugating discourses are reinforced. Social workers often work as group facilitators in community-based support centres, including those specialized in eating and body image problems. As professionals in positions of power, direct service providers participate in the production of knowledge about the people we claim to support through the language we use to name and define their behaviours, needs, and our corresponding practices (Chambon, 1999). At the same time, outside of medical institutions and often facilitated by practitioners coming from a variety of disciplines and training backgrounds, support groups may also potentially foster alternative approaches and knowledges. By studying the discursive practices in the facilitation of community-based support groups, this research hopes to generate useful knowledge for the ongoing development of support services for people dealing with eating and body image issues.

Chapter 2: Review of Literature

Gender, Discourse, and Eating and Body Image Issues

In the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM V), published by the American Psychological Association (2013), eating and body image issues are classified under the diagnostic categories of “avoidant/restrictive food intake disorder” (p. 334), “anorexia nervosa” (p. 338), “bulimia nervosa” (p. 345), “binge-eating disorder” (p. 350), “other specified feeding or eating disorder” (p. 353), and “unspecified feeding or eating disorder” (p. 354). These categories include detailed criteria to delineate and quantify ‘disordered’ characteristics and behaviours, such as “persistent energy intake restriction” (p. 339), “intense fear of gaining weight” (ibid.), “disturbance in self-perceived weight or shape” (ibid.), “Eating, in a discrete period of time (e.g., within any 2-hour period) food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances” (p. 345), and “[r]ecurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications” (p. 345).

Both mainstream clinical literature such as DSM V and critical feminist writers acknowledge that the vast majority of people diagnosed with ‘eating disorders’ are women and girls (APA, 2013; Moulding, 2006). The DSM reports the overrepresentation of women and girls amongst those diagnosed with ‘eating disorders’ as an objective fact, substantiated by statistics and presented as though it were simply a ‘feature’ or ‘characteristic’ of the ‘disorders.’ However, poststructural feminist analyses argue that “while psychological theories and associated therapeutic interventions make pretensions to gender neutrality, they are based on profoundly gendered assumptions about mental health and illness in men and women” (Moulding, 2006, p. 793-794). They theorize that ‘eating disorders’ and their ‘symptoms’ can alternatively be understood as experiences, subjectivities and practices that are constructed by and within “a multiplicity of contemporary western cultural discourses and discursive practices that constitute and regulate normative femininities" (Malson & Ryan, 2008, p.113). Drawing on Foucault's conceptualization of discourse, power, and subjectivity, this understanding of eating and body image issues rejects the western concept that individuals are completely autonomous, self-contained entities, assumed to own their individual characteristics and subjectivities independent of social contexts and experience (Guilfoyle, 2001). Instead, feminist theorists argue that negative body image and eating-related practices such as food restriction, bingeing, and purging are subjectivities and practices that are shaped through cultural practices, values, and norms that are profoundly gendered, as well as classed and racialized (Malson & Burns, 2009; Saukko, 2009; Sayers, 2009). Poststructuralist feminist researchers thus call into question the dominant, bio-medical discourses that attribute food and body image related problems to biological abnormalities, individual (female) psychopathology, and family dysfunctions (Bordo, 1993; Guilfoyle, 2001; Hepworth, 1999). As Hepworth (1999) argues, "phenomena are not simply the invention, idea or discovery of a historical period; rather, they have emerged through a set of interrelationships between knowledge, social practices and institutional authority" (p. 121). Through examining the work of the theorists who have been instrumental in shaping the understanding of eating and body image issues in professional practices as well as popular culture in western societies, feminist researchers demonstrate how the taken-for-granted understanding of 'eating disorders' as psychiatric concepts are constructed through specific discourses and contexts.

The History of the Conceptualization of 'Eating Disorders' and Their Interventions

Hepworth (1999) traced the writings of William Gull, who coined the term "anorexia nervosa" (p. 26) in 1874, and his contemporary E. C. Laseque to explain that the conceptualization of self-starvation as a psychiatric condition was made possible through specific historical developments, social conditions, and power relations. Underlying the social norms and values of

19th century Europe was the persistent moral ideology that could be dated back to the Middle Ages, which positioned women as inherently irrational, emotionally unstable, and susceptible to madness. Also, the 17th and 18th century saw the transition from religious to medical authority in the social control of people who were thought to be abnormal, leading to the rapid development of psychiatry in the 19th century. Under psychiatry, the medical conceptualization of "hysteria" (p. 37) was developed. Hysteria was a term originated from the Greek word for womb, defined as a "psychological effect of moral fault" (ibid.), and served as early explanations for women's refusal to eat. The competition between Gull and Laseque to be a leader in the emerging field of psychiatry and the exclusive discoverer of a new "nervous disease" (p. 32) also led Gull to claim that 'anorexia' was a psychiatric disorder. Hepworth argues that the existing discourses about women and psychiatry have shaped Gull's and Laseque's practices and documentation in treating individuals with eating-related problems. She writes, "[anorexia] nervosa was stated to be a female condition and was continually referred to as such throughout Gull's writings […] When male anorexia nervosa was addressed, Gull treated his observations with marginal importance" (p. 28). Gull's and Laseque's work has a long-standing legacy in shaping the understanding of eating problems as specifically associated with female psychology, which does not only perpetuate and justify intervention models that construct women as inherently irrational (Malson & Ryan, 2008; Moulding, 2006), it also renders invisible the distress that men experience around eating and body image. A recent study by Robinson, Mountford and Sperlinger (2013) shows that the experiences of and interventions for men dealing with eating problems continue to be under-researched, and the male participants describe difficulties and even shame in seeing themselves as having eating problems because such problems are socially understood as a "female issue" (p. 180).

Similarly influential were the writings of Hilde Bruch, a pioneer in the theorization of eating disorders in the 1930s. Her theories were instrumental in "defining the anorexic as someone with an insufficient autonomous self" (Saukko, 2009, p. 64) and associating eating problems with family dynamics, particularly mother-child relationships. Saukko (2009) argues that Bruch's psychodynamic theories about eating disturbances, obesity, and family dysfunctions were built on her work with Eastern European immigrant families in New York City and her negative evaluation of these families' apparently traditional cultures as an antithesis to American individualism. In the post-WWII period, the fear of communism and its mass culture, along with a disdain toward the newly affluent middle-class and their apparent complacency and susceptibility to mass culture, are also linked to Bruch's theorization of the typically middle-class 'anorexic girl' as dependent, having an "easily influenced disposition" (p. 66), and "lacking in terms of the American, rugged individualism, usually imagined as masculine" (ibid.). Her approach to intervention therefore focused on rehabilitating young women's sense of autonomy and self-control, while pathologizing emotionality and connectedness, which are typically associated with femininity. Malson and Ryan (2008) further theorize that characteristics that are typically associated with femininity are defined as the opposites of masculine traits. As such, hierarchical binaries such as active/passive, reason/emotion, autonomous/dependent, and in control/out of control "can be read as always-already gendered such that 'the feminine' is repeatedly aligned with the second term" (p. 116), whereby women are constructed and defined as what men are not. From Laseque's and Gull's early conceptualization in the late 19th century, to Bruch's psychodynamic theories 70 years later, it is evident that this gendered binary logic is deeply embedded in the understanding of eating and body image issues and the development of intervention practices. It is perhaps not difficult to imagine that gendered binaries continue to shape practitioners' understanding and practices today.

Gendered Binaries and Normative Femininity in Contemporary Interventions

Bordo (1993) points out that symptoms or features of 'eating disorders' as they are defined in psychiatric literature and practices, such as food restriction, preoccupation with body weight, physical fragility, passivity, dependence, and emotionality, are in fact exaggerations of stereotypical feminine traits and characteristics of the subject positions that women and girls are socially expected to take up in a western or westernized society. Bordo contends that “the discipline and normalization of the female body” (Bordo, 1993, p. 166) can be understood as strategies of social control within gender power relations, whereby patriarchal discourses regulate what is considered normal for women and shape the ways they experience their bodies. At the same time, feminist theorists argue that while various discourses position women as irrational and unstable, they are also expected to exercise attributes that are socially and historically constructed as masculine, such as self-control, particularly in the discipline of their bodies and the restriction of their appetites (Bordo, 1993). In fact, while being self-disciplined, driven, determined, and strong-willed are socially desirable characteristics that connote success in the western culture, the same characteristics are frequently associated with anorexia as signs of pathology (Burns, 2004; Malson, Clark & Finn, 2007). Thus, the contradicting “double-bind” (Moulding, 2006, p. 793) of contemporary femininity is thought to be part of the social and political condition that gives shape to problems related to food, eating, and body image.

At the same time, practices in the intervention of eating and body image difficulties continue to focus on individual psychopathology. Guilfoyle (2001) points out that “Psy [psychological, psychiatric, and psychodynamic] discourses have permeated into common-sense, western notions of the person” (p. 156). In these discourses practitioners and service users are afforded specific subject positions in their power relations with each other. While practitioners are often positioned as benevolent experts (Guilfoyle, 2001), patients in eating disorder treatment facilities, often female, are positioned in clinical literature as oppositional, manipulative, ambivalent to change, resistant to treatment, and lacking insight into their problems (APA, 2006; Hepworth, 1999; Malson et al., 2011). The treatment outcome for people diagnosed with anorexia and bulimia has long been reported as very poor, and the obstacles to successful outcomes are often located within the recipients of treatment (Burns, 2004; Malson et al., 2011). For example, speaking of clinical research, Wilson, Grilo and Vitousek (2007) comment that "trials fail because many individuals with anorexia nervosa reject treatment, drop out prematurely, and sustain few behavioral changes […] All of these outcomes are linked to patients' attitudes about their symptoms" (p. 203). A study by Masson and Sheeshka (2009) reports that an estimated 20-50% of individuals diagnosed with eating disorders will end treatment or be asked to leave treatment before its planned termination. Cognitive behavioural therapy is frequently recommended as an evident-based, first-line treatment for eating and body image problems (APA, 2006; Choat, 2010; Wilson et al., 2007), yet Wilson et al. (2007) report that it is only effective on 30-50% of patients diagnosed with bulimia, and that others "drop out of treatment or fail to respond" (p. 204). Likewise, in her study of an inpatient program, Gremillion (2003) observed that "multiple admissions to the unit and illness chronicity (like resistance to treatment) were cited as status quo and as unsurprising effects of anorexia itself" (p. 11). However, the treatment practices that are used are rarely questioned (Malson et al., 2011).

Power Relations between Professionals and Clients

Bordo (1993) suggests that "the medical model has a deep professional, economic, and philosophical stake in preserving the integrity of what it has demarcated as its domain, and the result has frequently been blindness to the obvious" (p. 53), such as issues of gender. Following the legacy of Hilde Bruch's theorizations, as well as the hierarchical gendered binaries that have persisted throughout history (Hepworth, 1999; Malson & Ryan, 2008; Saukko, 2009), treatment often focuses on the development of autonomy, rationality, and self-control, traits that are typically associated with masculinity, while pathologizing individuals living with eating and body image problems as irrational, dependent, and overly emotional, characteristics that are commonly regarded as feminine (Gremillion, 2003; Hepworth, 1999; Moulding, 2006). Yet, while stressing the goal of autonomy, patients are simultaneously expected to unquestioningly accept the interventions they are subjected to, which often involve constant surveillance, forced feeding, and social isolation through confinement to the treatment facility (Hepworth, 1999; Moulding, 2006). As discussed earlier, it is not uncommon for individuals to be labelled as resistant to treatment and to have their services withdrawn when they do not conform to treatment requirements (Masson & Sheeshka, 2009). Women are therefore positioned as always-already irrational and in need of help to become autonomous and assertive, yet they are labelled again as irrational and in need of regulation when they act assertively in refusing to conform to the procedures and rules that are imposed upon them (Moulding, 2006). Guilfoyle (2001) writes that "psychotherapy relies on a 'kind of self' able to work within and act in accordance with such discourses" (p. 160). In her study of an eating disorder treatment program, Moulding (2006) observes a form of power relations and clinical practices through which the patient is positioned as "child-like," "vulnerable," and "naïve" (p. 799-800), whereby female patients are expected to depend on the expert guidance of the male psychiatrists. Indeed, Malson et al. (2011) also suggest that treatment models that locate psychopathologies within the individual, combined with the culturally entrenched notion of an essential, unchanging self, can lead women to take up constructions of 'anorexia' or 'bulimia' as their identities and create tremendous difficulties for the women to imagine a life without eating problems. Thus, the "double-bind" (Moulding, 2006, p. 793) of contemporary femininity that is thought to contribute to eating and body image problems in the first place is also embedded in psycho-medical treatment methods (Moulding, 2006). These treatment methods may therefore entrench the very thing that they are attempting to eliminate and perpetuate women's experience of distress (ibid.).

Particularly, Guilfoyle (2001) draws on Foucault's concept of the "practices of the self" (p.

154) to theorize how power operates to eliminate resistance and produce compliant subjects. In his case example, power is exercised through discursive practices, such as techniques in psychotherapy and family therapy, to persuade the client to construct herself as ‘bulimic’ and abnormal and perceive her resistance to the practitioner’s recommendations as denial and pathological, thereby subjugating her own definitions of her difficulties and producing a desire to discipline her own self in accordance with the definition of normalcy within psychological discourses. Guilfoyle thus asserts that all interactions between practitioner and client are political; their relationship of power is structured by the western institutions of psychology and psychiatry. He advocates valuing individuals’ rejection of treatment as a form of political resistance, or, in Foucault’s term, “practices of freedom” (p. 160). He suggests that “a psy discourse might be used but also questioned, in the therapist-client dialogue, by invoking and elaborating local, specific discourses of resistance to psy as they emerge in sessions” (p. 173), thus undermining the hegemony of psychological discourses and rendering the use of psychological interventions as just one option amongst many. However, LeBesco (2009) further complicates the idea of political resistance against psychological and patriarchal discourses through health-damaging eating practices and rejection of treatment. She cautions that “resistance may be all well and good until we realize that women are sometimes physically and/or emotionally suffering as a by-product of this resistance – a resistance that they themselves do many times *not* embrace or recognize as such […] That women would lose their health or their lives is of much greater concern” (p. 147, author’s emphasis). Given that psychological discourses are deeply entrenched in our western culture, and that eating problems can lead to serious health consequences, many individuals living with eating difficulties may find comfort in psycho-medical definitions and interventions. Thus, to focus on cultivating a kind of political consciousness or resistance that individuals do not resonate with may run the risk of subjugating people’s own knowledge about their problems (Healy, 2000).

Nevertheless, LeBesco suggests that it is still important to develop approaches that support women to thrive without reproducing the oppressive practices within psycho-medical discourses.

Psycho-Medical and Gender Discourses in Community-Based Support

Psychological discourses and the medical model have historically been and continue to be a dominant voice in social work and social services (Healy, 2005). Between 1995 and 2002, over 4000 practitioners and educators from community-based agencies and schools have received manualized training through the Ontario Community Outreach Training Program for Eating Disorders on “how to conduct a comprehensive assessment, make early identification, and initiate psychoeducation programs to help clients with issues related to motivation and readiness to change” (McVey, Davis, Kaplan, Katzman, Pinhas, Geist, Heimaa & Forsyth, 2005, p. 36). This description once again locates the major obstacle to treatment in the clients and their lack of motivation to change. Moreover, the training is said to have developed from “best practices drawn from research carried out by experts in the field of eating disorders” (McVey et al., 2005, p. 37) based on treatment models used at two prominent Toronto hospitals. As such, a single manual is used to train practitioners coming from a wide variety of agencies across the province. In accordance with the psycho-medical discourses, eating and body image problems are again presented as objective, neutral facts with a definite set of symptoms that can be treated with a definite set of objective, neutral methods independent of the local contexts in which the treatment or intervention take place (Moulding, 2006). Also not discussed is the extent to which service users have been consulted in the development of this training program, if they have been consulted at all. Practitioners who have attended the training, the majority of whom are social workers, report increased “knowledge about eating disorders” and “confidence in treating clients with eating disorders” (McVey et al., 2005, p. 38). Dominant knowledge is therefore reproduced in local, community-based practices.

Group work is generally identified as an intervention method that can be beneficial for people dealing with eating and body image issues (Weber, Davis & McPhie, 2006; Zimpfer, 1990). For the past three decades, it is widely used in both hospital and community-based settings due to its cost-effectiveness, as well as its perceived potential to support participants in developing interpersonal skills, building relationships with others who share similar experiences, expressing difficult emotions, increasing insights into their problems, managing eating behaviours, reducing negative body image, cultivating awareness of societal pressures to be thin, and gaining positive means to approach food and the body (Choate, 2010; Harper & Shillito, 1991; McVey, Davis, Tweed and Shaw, 2004; McVey, Lieberman, Voorberg, Wardrope & Blackmore, 2003; Staples & Schwartz, 1990; Wanlass, Moreno & Thomson, 2005; Zimpfer, 1990). Particularly, expressing emotions and building relationships are identified as benefits of support groups in all of the group-related articles reviewed. Emotionality, connectedness to others, and being a caretaker are typically understood as feminine traits (Moulding, 2006; Sayers, 2009). Since eating and body image problem are socially constructed as women's issues, and the vast majority of people attending these groups are women, it may be argued that women attending these groups are *expected* to be supportive and emotionally receptive to each other (Moulding, 2006). For example, Choat (2010) promotes an interpersonal model of group work in which women's eating difficulties are assumed to be results of their "interpersonal deficits" (p. 359) and inability to maintain relationships; the model thus emphasizes the need for group members to "express feelings openly and directly" (p. 356) and to give feedback to each other's expressions. In a study with former group participants by Wanlass, Moreno and Thomas (2005), women's feeling of alienation in the group, their early termination, and their feedback of finding little benefits from attending groups were attributed to the women's own lack of openness and participation in sharing. On the other hand, group members can also share too much about their difficulties and be viewed by facilitators and group members as uncaring, as the authors report how “periodically the ‘sickest’ members dominated group sessions” (p. 56) and how “treatment-resistant patients minimized the needs of other members” (ibid.). In this context, if ‘resistance’ against treatment is identified as a hindrance to relationship-building, then belonging in the group is to be gained by conforming to the treatment model, along with its definitions of group members’ problems and solutions, on which the group is based. This can potentially silence the multiple, and sometimes contradicting, meanings that women give to their eating problems and recovery (Burns, 2009). Drawing on social movement theory and observations in a community-based support group, Koski (2014) theorizes that the collective identification with an “eating-disordered self” (p. 76) in need of help to work toward normalcy can motivate women to participate and sustain group attendance. However, this identification also constructs the ‘eating disorder’ as chronic, rooted in the self, and requiring constant monitoring through attending groups. As such, Koski argues that support groups can paradoxically inhibit recovery, which the participants define as enjoying “a life in which the eating disorder does not act as one’s primary interpretive frame” (p. 85). Furthermore, community-based support groups often have broad eligibility criteria, which can increase group attendance “by increasing the range of individuals who can and do identify as having an eating disorder” (p. 86), yet this can also further the medicalization of eating and body image issues and contribute to the advancement and continual expansion of diagnostic categories.

Group Work and Psychoeducation

Psychoeducation on health and the media seems to be a major focus particularly in school-based support groups and groups for young women (Harper & Shillito, 1991; McVey et al., 2003; McVey et al., 2004; Yager & O’Dea, 2008). In some of these groups participants are asked to discuss media influences on their body image and to take a “counter-attitudinal stance” (Yager & O’Dea, 2008, p. 184) against dieting and unrealistic ideal body shapes promoted in the media

(McVey et al., 2004). They are also taught to adopt an assertive communication style and to support each other in combating the negative comments regarding their appearance (McVey et al., 2003; McVey et al., 2004). Malson (2009) critiques that the role which culture plays in eating and body image issues "tends all too often to be understood *only* as idealised media images of thin women and the concomitant prescription […] to 'diet'" (p. 135, author's emphasis), while letting the wider cultural discourses "off the hook" (ibid.). The women and girls who struggle with eating and body image problems are consequently reduced to "fashion victims" (p. 136) who "have (irrationally) *over*-internalized an idealized *image* of female beauty" (ibid., author's emphasis), thus occluding an examination of the historically situated contexts, varied meanings, and "much of the inequalities of gendered power relations that are articulated in girls' and women's self-starvation" (ibid.) and other eating-related practices. While it is important to support young people in challenging various types of discrimination in media messages and everyday life, parts of these programs may also reinforce the hierarchical gender binaries embedded in psycho-medical treatment for eating problems by positioning women as always-already vulnerable to media influences because of their inherent irrationality, constructing this vulnerability as undesirable and in need of eradication, and combating this vulnerability with the instillation of rationality and assertiveness. Instead of addressing the gendered power relations and inequality that give shape to discriminative messages against women's bodies, in these support groups young women are taught to work on themselves in accordance with the ideal autonomous rational (male) subject (Malson & Ryan, 2008). The health and positive body image promotion strategies in the adolescent programs appear to result in short-term benefits such as enhancing body image, reducing dieting behaviours, and motivating the participants to advocate for school-wide awareness about societal pressures to be thin (McVey et al., 2003). However, the researchers found that these gains were not maintained at 12-month follow-up (McVey et al., 2004). A recent discourse analytical study with adolescent girls by Woolhouse, Day, Rickett and Milnes (2011) shows that, due to the emergence of health and body image discourses, noticeable shifts have occurred in the ways dieting and weight loss practices are constructed, yet discourses of individualism and normative femininity remain. On the one hand, the participants reject food restriction as “shallow” (p. 51) and an ultra-thin body as undesirable, reflecting the wish “to occupy the subject position of an autonomous individual who is not influenced by cultural messages” (p. 53). On the other hand, they are also aware of the social disadvantages and negative moral meanings that are associated with fatness, such as laziness and lack of self-control. Participants thus describe engaging in food and body management practices that are similar to ‘symptoms’ of ‘eating disorders,’ yet “construct their restricted eating as necessary to achieve a *healthy* body” (p. 53, authors’ emphasis). Evaluating school-based prevention and intervention from a feminist perspective, Piran (2010) suggests that these programs often expect individual attitude change, such as reducing weight concerns, while disregarding participants’ social environment, such as the culturally normative idealization of slenderness and the ubiquity of body image dissatisfaction and weight loss practices (Malson et la., 2011). As a service user comments: “Recovery is like a mandate to do what everyone else is working not to do” (Hardin, 2003, p. 10, cited in Malson et al., 2011, p. 29).

Alternative Models of Support Groups

Feminist practitioners theorize that group work can support the development of “curative communities” (Black, 2003, p. 127), whereby women create their own alternative social environment in which the social and cultural contexts that contributes to eating issues are examined and countered. Instead of providing education about the western “fat-phobic” (Black, 2003, p. 128) culture and viewing women and girls’ eating problems as maladaptive responses to societal pressures, the feminist support group that Black (2003) has developed aims to explore the relationships between the often subjugated positions of women within society, eating difficulties, and negative body image. Black and other feminist practitioners further suggest that a non-blaming, non-pathologizing approach helps to contextualize eating and body image issues as constituted in gendered and racialized discourses and power relations (Burns, Tyrer & the Eating Difficulties Education Network [EDEN], 2009). They also emphasize the centering of participants' own knowledge, resources, and hopes rather than prescribing professional or expert knowledge in defining and solving individuals' problems (Burns, Tyrer & EDEN, 2009). Nevertheless, Guilfoyle (2001) cautions that feminist or other alternative models of support are not immune to power relations and discourses that silence and subjugate, as power infuses all social interactions. Weber, Davis and McPhie (2006) describes a narrative approach to a support group program that "challenges internalising or individual pathologising language, arguing that something like anorexia, bulimia or depression arises in a context of cultural, familial and social relationships and experiences" (p. 393). It also explores the ways through which participants resist and challenge the influence that eating and body image issues have on their lives. However, perhaps in an effort to gain legitimacy in the mental health field, the authors continue to rely on standardized psychological measurement tools such as the "Eating Disorder Inventory" (p. 397) to evaluate the effectiveness of the group program. Their study thus runs the risk of reinscribing the pathologizing language and concepts that it seeks to resist by measuring and reframing the participants' experiences in terms of individual behaviours, risk factors, and symptoms as defined by psychological discourses. Guilfoyle (2001) therefore advocates developing practice approaches that highlight operations of power, both in our work with clients and "in our reflections on our position within broader networks of discourse" (p. 175).

Gaps in Literature

Critical analyses of practitioners' approaches in both individual and group interventions mostly focus on institutional-based eating disorder treatment (Burns, 2004; Gremillion, 2003;

Guilfoyle, 2001, 2009; Hepworth, 1999; Malson & Ryan, 2008; Malson, Clark & Finn, 2007; Moulding, 2006). One discourse analytic study by Moulding and Hepworth (2001) examines the workers' approaches in a community-based health promotion program for the prevention of eating problems, but the program does not provide support groups, and the study is relatively dated. Two Canadian studies by McVey et al. (2003) and McVey et al. (2004), along with an American study by Harper and Shillito (1991), focus on community-based support groups for adolescent girls; however, they mainly describe and evaluate the effectiveness of the support groups without critically examining the approaches and practices that are used. A study by Piran (2010) examines school-based prevention and intervention programs from a feminist perspective, which include support groups; however, this study focuses on the overall structures of these groups rather than the actual practices that are used by the program facilitators. A few authors have written about community-based support groups that are specifically developed from feminist or narrative frameworks; yet they also mainly focus on describing how the agencies' overall approaches align with frameworks that challenge dominant theories of eating disorders (Black, 2003; Burns, Tyrer & EDEN, 2009; Weber, Davis & McPhie, 2006), rather than examining how individual workers take up these frameworks and construct their own understanding and practices in group facilitation. This study thus builds on existing literature by critically examining service providers' practices in community-based support groups in current, Canadian contexts.

Chapter 3: Research Design

Theoretical Framework

This research uses a qualitative design based on discourse analysis and a critical feminist perspective. The research questions are stated as follows:

- What are the discourses that constitute and are reinforced by the ways practitioners construct their approaches and practices in facilitating community-based support groups for adults living with eating and body image issues?
- What are the power relations that are implicated in the ways practitioners construct their approaches and practices?

This discourse analytic study is situated in a poststructuralist paradigm, which understands all meanings, knowledge, practices, and realities as constituted through discourses (Healy, 2000). It is informed by the increasing number of feminist discourse analytic studies on eating and body image issues (Burns, 1994; Hepworth, 1999; Malson et al., 2011; Moulding and Hepworth, 2001), many of which draw on Foucault's concept of discourse, which Parker (1992) defines as "a system of statements which constructs an object" (p. 5). It is believed that multiple overlapping and contradicting discourses are at work in every social context, in which individuals' understanding and practices are shaped by a combination of these discourses (Healy, 1999). Foucault is concerned with how power operates through discourses to delineate what can be counted as truth and who is capable of speaking the truth (Healy, 2000). As such, discourse analysis also seeks to examine how individuals are positioned within relations of power, whereby different subject positions are constructed with varying degrees of privilege or subjugation based on the extent to which they align with the truth claims within various discourses (Parker, 1992). Power thus operates by inviting individuals to take up particular subject positions that are discursively constructed as desirable (Heron, 2005; Parker, 1992). Since poststructuralists believe that discourses and subject positions are constituted and reinforced through everyday talk and practices, and that power operates from the bottom up through these practices, they give “priority to local contexts and social practices as sites of analysis” (Healy, 2000, p. 51). As Lazar (2005) explains, the perpetuation and hegemony of ideologies are “largely accomplished through discursive means, especially in the ways ideological assumptions are constantly re-enacted and circulated through discourse as commonsensical and natural” (p. 10). This study therefore aims to examine the particular discourses, subject positions, and power relations that are reproduced through the ways practitioners define and construct their practices and approaches, and to deconstruct the truth claims within discourses that are framed as unquestionable and natural. As such, this study is also aligned with the epistemological tradition of constructionism, which focuses on the ways “social realities are produced, assembled, and maintained” (Silverman, 2013, p. 107). It is limited by its small sample size; however, as a constructionist study it does not aim to produce universally generalizable results that are applicable to all support groups for eating and body image problems. Rather, it attempts to illuminate the discourses and social processes that make various social practices possible (Silverman, 2013); the interviews are thus regarded as specific social contexts in which social realities are constructed and discourses are reproduced through language (van Dijk, 1993). As Parker (1992) suggests, a study of discourse dynamics and “an attention to language can also facilitate a process of progressively politicising everyday life” (p. 21), whereby opportunities for the resistance of domination and subjugation can be located through understanding how power is locally exercised and sustained (Healy, 2000). Critical examinations of professional practices demonstrate that psycho-medical discourses and practices often reinscribe the social norms and values that inform eating and body image issues in the first place (Burns, 2004; Gremillion, 2003; Hepworth, 1999; Malson & Ryan, 2008; Moulding, 2006). It is therefore important to examine local, community-based practices in order to envision approaches that are more supportive and less pathologizing. While discursive practices can often be oppressive, Parker (1992) stresses that discourse analysis elaborates on “meanings that go beyond individual intentions, discourses that are transindividual” (p. 7). This understanding aligns with my approach to this research in that it moves the investigation away from identifying ‘bad’ practice or ‘bad’ practitioners and instead cultivates a non-blaming, non-individualizing attitude in examining the discourses that shape practice (Burns, Tyrer & EDEN, 2009). Also, I enter the study with the assumption, based on my own experience of various forms of services for eating problems as a client and a service provider, that professional knowledge is dominated by psycho-medical discourses of eating disorders. A short art-making exercise is therefore incorporated as part of the data collection methods because visual art can serve as “the point of departure for dialogue” (Leavy, 2009, p. 227), from which participants may elaborate on experiential knowledges that words may not fully express, as well as alternative understandings that may disrupt dominant professional paradigms, thus possibly creating space for responses that may contradict my assumptions.

This study is also grounded in a critical feminist perspective, which asserts that eating and body image issues are constructed by and within “a multiplicity of contemporary western cultural discourses and discursive practices that constitute and regulate normative femininities” (Malson & Ryan, 2008, p.113). Certainly, through the lens of discourse analysis the subject positions of men can also be understood as discursively constituted and regulated through relations of power. However, as Lazar (2005) explains, gendered subjects are affected by power in different ways. A critical feminist perspective considers gender as an ideological structure that “imposes a social dichotomy of labour and human traits for women and men” (p. 7), in which masculinity is privileged while femininity is subordinated. It also recognizes that “the overlap of the gender structure with other relations of power based on race/ethnicity, social class, sexual orientation, age, culture and geography means that gender oppression is neither materially experienced nor discursively enacted in the same way for women everywhere" (p. 10). Thus, while this study mainly focuses on eating and body image problems and gender, the interviews also address practitioners' approaches to issues of race (see Appendix A: Interview Questions). Aligned with the feminist political goal of social transformation and a just society that opens up opportunities for everyone, this study systematically examines how dominant discourses are reproduced as well as resisted in the facilitation of community-based support groups, with the hope of opening up new possibilities for practice (Gringeri, Wahab & Anderson-Nathe, 2010; Lazar, 2005).

Data Collection

I conducted seven semi-structured, individual interviews with direct service providers who have facilitated support groups in community-based settings. While it was important to interview social workers to generate insights regarding social work education, training, and awareness in the area of eating and body image issues, I also aimed to interview service providers from different disciplines, as it may produce results that the social work profession can learn from. Considering also the time constraints in this project, convenient as well as purposive sampling methods were used. To maximize the diversity in the range of perspectives in this study (Silverman, 2013), I did not interview practitioners I had worked closely with. I first contacted my acquaintances through my work at a community-based agency; four facilitators agreed to participate. I then contacted three practitioners I did not personally know, one through snowball sampling, and the other two through LinkedIn, a professional networking website. All of the participants identify as women; six are white, and one identifies as South American immigrant. Their education and training backgrounds include social work (SSW and MSW), expressive arts, counseling psychology, health and behavioural sciences, and nursing. All have facilitated groups for eating and body image issues in community-based agencies in Ontario; two have also facilitated groups in universities in

Ontario, and one has facilitated adult support groups in British Columbia. The length of time that they have been facilitating adult support groups range from 9 months to 22 years.

Five interviews were conducted in person, one was conducted through video Skype, and one was done by phone. The in-person interviews began with a 15-minute art-making exercise. The participant were invited to use collage materials, drawing, or words to create an image that represent the kind of support they hope to facilitate in a support group for eating and body image issues. Art supplies were provided. All of the participants in the in-person interview agreed to take part in the art-based exercise, to have photographs taken of their artwork, and to have images of their artwork included in the final report. The participants were then invited to talk about the image created, followed by discussions based on a series of open-ended questions (see Appendix A: Interview Questions). The art-based exercise was omitted in the Skype and phone interviews; however, in an attempt to approximate the conditions for creative reflections in the in-person interviews, the participants were asked to share the words or images that came to mind when they thought about the kind of support that they wished to facilitate in a support group for eating and body image issues. The duration of the interviews ranged from 35 to 85 minutes. The majority of the interviews were conducted at the participants' offices; participants who met with me outside of their workplaces were reimbursed for their travel expenses. All of the interviews were audio recorded and transcribed verbatim for analysis. Handwritten notes were taken to address important points during the interviews. If participants shared information while the recording device was switched off, permission was asked for the information to be noted and used in analysis (Hepworth, 1999). Photographs were taken of the artwork created by the participants.

Ethical Considerations

A consent form was provided to each participant to briefly explain the purpose of the study (see Appendix B: Consent Form). They were informed that their participation was voluntary and they had the right to withdraw from the study at any time. Any information, including images, they provided could be changed or removed upon their request, until May 1, 2014. Only I have access to the recordings and transcripts of the interviews. All recordings, transcripts, and photographs are stored on my computer in a password protected folder and handwritten notes in a locked cabinet in my home. The photographs of participants' artwork are included in the final report; this was specifically pointed out to the participants so that they may decline to have their artwork photographed. I have offered to send the participants a summary of the findings. They were also informed that the data will be kept securely for up to five years for the purpose of potential future research, but all recordings and transcripts will be erased and notes shredded after January 2019. In the transcripts and final report all personal identifying information are removed, such as the agencies where they have worked, and each participant is represented by a single letter.

Data Analysis

The initial organization and analysis of the data are informed by the technical process described in a discourse analytic study by Woolhouse, Day, Rickett and Milnes (2011). The interview transcripts were read line by line several times. Chunks of texts were then grouped together by discussion topics. Within each discussion topic, themes that emerged from the texts were identified using the participants' own words, and chunks of texts were coded according to these themes. Often, a chunk of texts that is coded with one theme may contain sentences that can be interpreted as belonging to other themes. The recognition of specific contexts is crucial in a poststructuralist analysis of discursive talk and practices (Healy, 2000). The chunks of texts or paragraphs are therefore kept intact as much as possible in order to take into account the relationships between the lines of texts or the context around which a concept is constructed in discussion, rather than taking apart the texts line by line and running the risk of interpreting the participants' words out of context. As such, the themes are not at all mutually exclusive. There are overlaps and interconnections between themes as well as contradictions within themes. This reflects the poststructural understanding that “in every context there are a number of discourses operating, which may be overlapping, distinct or discontinuous, and understanding and action in context will be shaped by a combination of discourses” (Healy, 2000, p. 41). Throughout the analysis process I continually re-examined the texts within each theme, questioning my previous readings and organization of the texts while exploring other possible interpretations. The chunks of texts were rearranged and themes were redefined and renamed until all of the texts were grouped into themes that, according to my interpretation, best described and summarized them. No analysis of the participants’ artwork was made beyond what the participants said about them. Moreover, in order to preserve the integrity of the participants’ narratives about their artwork, in this report the captions that accompany the images of the participants’ artwork contain their full descriptions of what they have created.

Discourse Analysis

I then examine the texts within each theme to identify the discourses that are at work in the participants’ constructions of their approaches and practices of support (Woolhouse et al., 2011). Following a similar study conducted by Moulding and Hepworth (2001), which focuses on health promotion workers’ constructions and understanding of their practice approaches, Parker’s (1992) framework for discourse analysis is used to guide the interpretation of the data. This framework involves 10 criteria and 20 associated questions for the analysis of selected texts. I understand the purpose of Parker’s criteria and questions as identifying the following elements within the texts:

- The words to name the discourses that are at work in the texts by “exploring the connotations, allusions and implications which the texts evoke” (p. 7)
- The relationships and contradictions between the various discourses within the texts
- The subject positions produced through these discourses

- The worldviews and taken-for-granted realities that these discourses produce
- The ways through which these discourses emerge in history
- Institutions that are strengthened or attacked when these discourses are employed
- The groups of people who benefit or suffer harm from these discourses
- The groups of people who have a vested interest in promoting or suppressing these discourses
- The connections between these discourses and other discourses that sanction the oppression and subjugation of alternative knowledges

Limitations

Parker has stated that the identification and analysis of discourses are “best done with other people” (p. 7). Due to constraints in time and resources I am not able to formally collaborate with others in the research process. My role as the sole researcher and analyst in this study is therefore a major limitation, as researchers, like anyone else, are never outside of discourses. My view is always partial, and my understanding always incomplete (Healy, 2000). As much as I attempt to “‘[step] back’ from our immersion in such discourses as ‘reality’” (Rossiter, 2005, p. 7), the design, the data collection methods, the analysis, and the reporting of this research are nevertheless shaped by my prior learning, histories, subject positions, in ways that I may or may not realize (Napier & Fook, 2000). Another person may interpret the data in different ways. The art-based component in this study is limited to its role as a data-gathering tool that supplements the interview, as a starting point for the participants to connect with what is important to them and to reflect on abstract concepts such as support. No observations or interpretations are made about the artwork beyond what the participants say about them to avoid making interpretations out of context. However, this way of using the art can overlook much of the rich data that the visual images contain. Furthermore, I substantiate and ground my analysis of service providers’ practices using the work of poststructuralist feminist theorists, and try to incorporate the perspectives of service users from other studies; however, the voices of those living with eating and body image difficulties are largely left out of this process of knowledge generation about the practices and services that affect them. Throughout the research I use the term ‘eating and body image issues’ to move away from diagnostic labels; however, this also risks conflating the diverse practices, subjectivities, and experiences relating to food and the body by subsuming them under a singular category. It leaves out eating practices and concerns that do not involve difficulties with body image, or vice versa, issues that are nevertheless highly pertinent to the examination of gendered discourses and their norms. This can potentially perpetuate the popular representations and assumptions of ‘eating disorders,’ which equate eating problems with weight management and the desire to be thin, thus overlooking the significance of practices such as overeating as an effect and articulation of gender inequalities (Malson, 2009). More broadly, due to time limits as well as my own interests, which are shaped by my learning and work experiences in the field, the scope of this study mainly focuses on gender, particularly the discursive constructions and practices that affect women, thereby leaving out the discourses and discursive practices that constitute men’s experiences of eating and body image difficulties, as well as much of the discussions about race, class, age, sexuality, and gender expressions that are closely linked to eating and body image issues and intervention practices (Bordo, 2009; Gremillion, 2003; Nasser & Malson, 2009). Nevertheless, it is my hope that my findings and analysis can make some small contributions to the diversification of knowledges regarding eating and body image issues, with the aim of creating new possibilities for just practices (Healy, 2000; Rossiter, 2005).

Chapter 4: Findings and Analysis

The discussion topics and the themes within each topic are organized as follows:

- Support as imparting knowledge
    - “A predictable structure”
    - “Rules do make people safe”
    - “A new foundation can be given through psychoeducation”
    - “To try and find that true self”
    - “Being authentic”
    - “It’s really a construction”
- Support as creating space for others’ knowledge
    - “You have to just be where the clients are at”
    - “We share leadership”
    - “I don’t want people to just be able to talk to me”
- Support as facilitating connections
    - “I’m not alone”
    - “People don’t have to participate at all”
    - “Have awareness of the people in the group”
    - “Not everyone becomes friends”
- Support as solutions to challenges of difference
    - “Bonding over this terrible thing”
    - “One has to be curious, and not make assumptions”
- Support as an alternative and a bridge to treatment
    - “This group is not a treatment”
    - “The groups as a stepping stone”

Figure 1. L.'s artwork.

"So I think there's a part that first came to mind is doing a new foundation, which is at the bottom. So I think in a support type of setting, a facilitator is there to provide a new foundation for people who are struggling with their eating or perception of their body. A new foundation can be given through psychoeducation, it could be awareness, it could be sitting in complete silence 'cause you're giving somebody space to talk. I put a tree with growth next to it, I think support groups offers so much growth. No matter what stage you are at, the first day you come in, and if you make it through the eight to ten weeks of group, growth happens whether you think it will, um, whether you can pinpoint it yourself, or it's just the facilitator or other clients that see it. So I think growth happens, and I think that's a beautiful part of support. I put a little wolf and its baby, um, for love, um, and I think love in that actual picture, it's the closeness, the connection, and it kind of made me feel almost how birds feed their young. So, um, nourishment, and that can be nourishment by food, or nourishment by just connections and touch and support […] I did like a rainbow selection because I think safety needs to be a part of support, and that's recognizing anybody's background, sexual background, ethnic, religion, absolutely anything that should never be a factor that would change the support you receive. At the top I have unexpected, support group, what I have learned as a facilitator is you never know what's going to happen, um and I think the clients don't know what's going to happen, whether it's them with other people, or them and themselves. Um there's sort of like a blurry photo of a woman, the way I see it, in the middle, and I have one hand with 'relief,' one hand saying 'yes.' So I think she is reaching up towards the unexpected and she's reaching with the hopes that things will change. I put a little label of pain around her midsection. I think that the hunger and struggle um and perceptions of our bodies brings a lot of pain to people. Just below 'pain' there's the word 'whole,' because I think in support groups you have the fight and the struggle between your struggle and how you identify in becoming whole, and how you perceive yourself." – L.

Support as Imparting Knowledge

Participants spoke about the knowledge and theories that informed their practices in creating a supportive environment in the groups. Facilitators' knowledge is therefore imparted upon the clients or group members through various practices of support, including the implementation of a predetermined group format, the establishment of what safety means in the group and the rules to maintain this feeling of safety, the provision of education especially regarding the psychological, familial, and social issues that are understood by participants as contributing to eating and body image issues. Specifically, a recurring theme in the participants' discussion of support is the use of various psycho-educational tools and practices that aim to assist clients to become aware of, articulate, and manage the emotions that are understood as causes or manifestations of 'eating disorders.' Moreover, participants drew on their own personal and emotional experiences to describe their approaches to support, and identified authenticity as a character trait that contributes to group facilitators' effectiveness in building trust with clients and modeling 'authentic' self-expressions. They also discussed how gendered social and cultural norms contribute to experiences of distress about eating and body image, but described allotting limited time to address these issues, depending on the group members' needs and interests.

"A predictable structure": Implementing a predetermined and consistent group format. The participants described a very similar structure or sequence of events that they implement in the groups they facilitated, as exemplified by A.'s description:

> A: I would start with kind of the rules, right? So talking about what safety is, and then I would encourage people to do kind of a check-in, so kind of go around and say what they bring to the group […] And then normally kind of around a half way point I might introduce some sort of a skill or quote or something for them to think about, and we would kind of do a check-out.

The importance and helpfulness of a predictable structure seemed to be constructed through participants' understanding of eating and body image issues.

> O: I'm always amazed by the amount of people that, there's no structured meals in their family. It's the structure too, a predictable structure.
>
> L: Knowing how difficult a lack of structure is for people who identify with body image concerns or eating disorders. Um, it's often helpful to know when you're coming to support group and you're feeling nervous or anxious or scared that, okay this is sort of how it goes, everyone will take a turn, we'll do this for this amount of time, these are topics that often come up. Um that I think is sort of get people prepared to open up.

As L. mentioned, the positive effects of having a predictable structure were related to the ways it encouraged group members' participation, such as sharing with other group members and sustaining group attendance.

> A: This partly is my own needs I guess, but I feel that there needs to be a little bit of structure. In terms of, I generally would say 'okay this is the topic that we're focusing on' and have some sort of exercise there. Um, to either as an ice breaker, or […] what I found is that they like to have something tangible to bring home with them. Um some people don't, but it at least gives the people that do, something.
>
> N: These groups, none of them did you sign up for, and yet they sustained themselves, so that's where the model is so important, because if it wasn't something that worked it just wouldn't have sustained itself.

It can be argued that psychological and psychiatric discourses are embedded in how the participants construct the importance of establishing a consistent or predictable group structure. It is perhaps unsurprising that participants' understanding is shaped by these discourses, as professional education and training about eating and body image issues have historically been and continue to be informed by the work of several prominent figures in psychiatry, such as Hilde Bruch (Hepworth, 1999; Saukko, 2009). Indeed, the link that O. makes between the importance of a predictable structure in support groups and the lack of structured meals in people's families seems to reflect Bruch's theorizations that tie eating difficulties to family problems (Gremillion, 2003; Saukko, 2009). Discourses of psychology and family therefore work in tandem to reinforce the importance of group structure in this context. As Gremillion (2003) writes, in regards to contemporary treatment for eating problems, "approaches to patient care are designed to model a kind of parenting that patients have presumably lacked: the provision of a predictable and consistent ‘environment’ that is in the interest of patients’ safety […] coupled with an encouragement for patients to express themselves freely” (p. 122). Also, analysis of historical documents regarding the development of anorexia nervosa as a psychiatric entity, as well as critical feminist analyses of clinical practices for eating problems, reveal that within the psychiatric and psychological discourses the concept of ‘eating disorder’ is built on gendered binaries that position the feminine as irrational and emotionally unstable, the opposite of masculine traits (Hepworth, 1999; Malson & Ryan, 2008; Saukko, 2009). Therefore, discourse of gender is also involved in fixing emotional instability as a character trait of people identified as having ‘eating disorders.’ Support groups as a form of intervention for eating problems may then counter this instability with an environment of stability through a predictable group format. This analysis does not aim to negate the idea that establishing a consistent group structure can be beneficial for people attending groups. Rather, it is concerned with how the understanding of predictable structure as important and necessary is shaped by discourses that *essentialize* people living with eating problems as being irrational and unstable, and how these essentialized ideas may therefore be repeatedly reinforced through practices that aim to establish structure. For example, in L.’s comment, the helpfulness of outlining a predetermined group format for the new client is constructed through her understanding that a lack of structure is particularly difficult for people with ‘eating disorders.’ This can position the clients as in need of guidance and of decisions being made for them in terms of how they will proceed in the group; the need for structure is therefore attributed to the clients’ individual needs and difficulties. However, A. acknowledges that her practices of establishing group structure is partly related to her own needs and that some clients do not prefer the group structure that she sets out. Thus, her comment creates an opening to challenge the essentialized idea that people living with eating problems need structure, and to understand how this essentialization can conceal facilitators’ own needs and investments in predetermining a group format. Healy (2000) writes that truth claims are made possible through oppositions. Claims that position clients as in need of guidance thus at the same time position the practitioner as capable of providing guidance. Heron (2005) explains that desire is integral to the operation of power through discourses, as desire "produces individual investments in particular subject positions" (p. 347) created by discourses. Within psychological and psychiatric discourses, those who with specialized training and education about the human mind and behaviours are afforded positions of authority to determine what counts as truth and what kinds of practices are helpful for which mental health issues (Healy, 2000). Practices of establishing group structure can therefore be understood as a way to maintain this position of authority within psychological as well as professional discourses in the context of social services, in which practitioners are expected to demonstrate knowledge and effectiveness in guiding and having control over the behaviours of those who are perceived as unstable (Heron, 2005). As such, upon closer examination the seemingly straightforward practices of establishing group structure can reveal the ways through which power operates through everyday professional practices to maintain and reinforce the domination of the psychological and psychiatric discourses in the understanding of eating and body image issues.

"Rules do make people safe": The importance and facilitation of safety. The concept of safety was emphasized and mentioned repeatedly throughout the interviews by all but one participant as an important component of the support groups they facilitated. The participants shared that safety was facilitated through the establishment of guidelines or rules.

> O: Well I mean there are rules, because rules do make people safe. I've had to be more lax about my no-drug rule […] like there's no taking like Ativan [medication to relieve anxiety] or anything in my group […] Um, there's no food obviously. You're allowed to have some kind of beverage.

> N: One of the things that I feel strongly about is people not talking about their specific symptoms. And so it's a way of keeping the group safe.

N. further explained how talking about “specific symptoms” could jeopardize feelings of safety by linking the idea of safety to her understanding of the typical behaviours and thought process of people living with eating and body image issues. She explained that people would eventually come to appreciate and desire the sense of safety that could be gained by adhering to the rules.

> N: I’ve had some people, many people over the years get really upset about them [the guidelines], and almost all of them if they stay on for, and come for a few weeks, a few weeks or a few months later, they are telling the new people ‘I get it whey we shouldn’t talk about it.’ Because it becomes unsafe. The energy, when people start talking about their behaviours, or diets, or weight, or shape […] people can become competitive, without meaning to but all of a sudden they’re thinking, ‘ugh, she’s 5’6”, and she weighs that much?’ And so it becomes another number in their head. And when you’re dealing with a group of people that know they’re inclined that way anyway, or they’ll compare how much they eat […] or ‘I didn’t know about that behaviour, maybe if I did then I would look like her.’ […] the mind, it’s not that people are happy that their minds go there but they do.

For N., effective ways of dealing with issues that may be “unsafe” for group settings involved working with co-facilitators:

> N: I believe that it’s really important to have two people running groups […] it creates more safety in the group. Because if something happens someone can step outside with someone, um if there’s a medical emergency, or if something’s come up that, someone’s having a psychotic experience.

Based on the participants’ comments, the rules of safety are mainly determined by group facilitators. This again reflects the psychological and psychiatric discourses in which those who are perceived to hold specific knowledge sanctioned by the discourses are granted authority in defining what can or cannot be said, what are appropriate behaviours, and what is considered safe or unsafe (Healy, 2000). In this context, behaviours or topics of discussions that are considered unsafe are those that can prevent group members from participating in ways that are deemed appropriate by the facilitators. Particularly, N. identifies discussing eating-related behaviours and weight management practices as unsafe because of the specific ways that people with eating problems think. Bordo (2009) has long been arguing that eating problems and body insecurities are a “cultural problem” (p. 53), reflecting the gendered, moral, and consumerist norms and values of historical as well as contemporary western culture. Other studies suggest that ‘symptoms’ of ‘eating disorders’ are not very different from culturally normative practices of dieting and weight management, which are driven not only by the prevailing cultural ideal of the thin female body (Malson, Clarke & Finn, 2007; Malson et al., 2011; Piran, 2010; Woolhouse et al., 2011), but also by the discourse of health and its state-sanctioned “‘war’ against an alleged global ‘epidemic of obesity’” (Malson et al., 2007, p. 417). Drawing on psychological discourse, clients’ thought process around food and the body in N.’s comment is individualized and pathologized as a cognitive problem and a characteristic of people living with ‘eating disorders.’ Detailed discussions in group about food and weight management practices may indeed add to clients’ feeling of distress and it may indeed be extremely helpful for facilitators to intervene in such discussions. The critique presented here is not concerned with whether or not the rule of “not talking about the symptoms” is helpful; it is concerned with the individualization of feelings, thoughts, and behaviours within the process of constructing this rule. As Bordo (2009) argues in regards to eating and body image issues, “the situation will not change until the culture does” (p. 54). Practices that reinforce and are built on the individualization of problems can obscure the cultural norms and values that give shape to these problems, thus limiting the possibilities of effecting cultural changes.

A. described certain topics of discussions as unsuitable for group settings but discussed the importance of creating space for them in individual settings:

> A: These are the things that are probably best discuss with me on a one-on-one basis after the group […] And also make sure part of safety is at the end of the group, kind of spending a good 10-15 minutes checking out and making sure everyone’s okay before they move on kind of thing.

When asked about what issues may not be suitable in group settings, A. expressed concerns about the tension between silencing some group members and endangering the sense of well-being for others. She also seemed less than adamant about prohibiting discussions of food in groups.

> A: Sometimes people will bring something up and the whole group get really derailed there […] Anything to do with self-harm, or suicidality, to talk about that after group, which, that's hard, because that really shuts down certain people that are having those concerns […] they say you can't talk about food, which I'm a little on the fence with, because I think that you do have to talk about food to be able to get over this […] you could have someone in the group that would really derail if they heard someone talk about what they ate, right? So, it's hard, really challenging.

O. explicitly disagreed with rules about prohibiting discussions of food, brining into consideration the culturally normative practices of dieting and weight management:

> O: And you can say Oreo cookie, because in the real world, people aren't going to be like 'oh I can't use numbers, I can't.' I don't believe that. If you can't say 27 pounds and have everyone give you a dirty look […] I can't play by all the rules, because no one out there is playing by the rules.

The concept of confidentiality was also described as a part of the construction of safety in support groups. They link confidentiality to the physical space in which the group is held and specific rules around what could be said in the group.

> A: Making sure that it's very clear that there's confidentiality so that you know the room is, it's not very close to another room where people might be, you know that sort of thing.
>
> N: And it's being explicit about confidentiality […] being explicit that that means not saying, especially in an open-ended group […] I would say, it's confidential with people in the group at this time. And so the next session there may be a few different people, and so don't bring up someone else's issue […] sometimes again people might gawk in the beginning but they quickly, actually felt safer as a result.

The concept of safety itself can be understood as a discourse that works in collaboration with discourses of gender and psychology. From the participants' discussions it can be argued that the discourse of safety positions the clients as in need of protection. Specifically, they are constructed as in need of careful protection from themselves and from each other through rules that delimit what can and cannot be said in the groups. They are also instructed to protect each other by keeping strict rules of confidentiality. A. uses the word "derailed" to describe how clients would react if someone brings up a topic that is considered "unsafe." The image of a train going off its rail conjures up the ideas of complete loss of control and serious harm, which can be understood as connoting the emotional instability and fragility that is associated with the characteristics of women living with eating problems as constructed by gender and psychological discourses. This understanding justifies the importance of safety rules. However, O.'s rejection of and A.'s hesitation about the rule that prohibits discussions about food in groups can be viewed as an opening to resisting assumptions within the psychological discourse that individualize preoccupations with food and body weight as signs of pathology, thereby shifting the attention to the cultural norms that give shape to eating problems and body image issues.

"A new foundation can be given through psychoeducation": Educating clients. When asked about what informed their approaches to practice, the participants described not only the theories that informed their practices but also how such theories could help clients gain useful knowledge or new perspectives in regards to behaviours or characteristics that were specific to 'eating disorders.'

> L: I think in a support type of setting, a facilitator is there to provide a new foundation for people who are struggling with their eating or perception of their body. A new foundation can be given through psychoeducation, it could be awareness.
>
> R: What I think is, the idea is that people with eating disorders are doing the best they can, when they arrive to the group. And at the same time, they can still do, ah, better, they can still improve. So that I got from dialectics, especially from the book of Marsha Linehan, um, how to use skill-building training to treat borderline personality disorder. DBT [Dialectical Behavioural Therapy], yes. […] and accepting whatever reality they have, at the same time.
>
> M: The idea is that, um, mental health problems can take up our identity and become a dominant view that we have of ourselves. And so narrative therapy program, or a group […] was based on sort of ah, having a more positive view of ourselves rather than being consumed by the eating disorder identities, for the lack of a better word.
>
> N: I mean really that's […] feminism, and oh, motivational stance, or motivational interviewing […] not to judge behaviours, rather being inquisitive. So um it's a tool of getting people to sort of explore things […] to explore you know thinking about the underlying reasons behind their behaviours.

When discussing their theories of practice, several participants distinguished between general support groups and groups that are explicitly built upon established models of therapy or treatment. A. did not associate her practices in support groups with particular theories, L. described an overarching approach she used in both general support and clinical groups which was not associated with specific theories, while M. acknowledged that her practices in both groups were influenced by theories that she subscribed to.

> A: I think that's where you get into the difference between kind of a treatment approach group and a support group. Um, what I find is that there may be time where it's um, there's support group that has more of a clinical base, and then I would be using more of a CBT approach […] so in terms of theories in practice it really is more just about you know following the regular ethical practices and ensuring that I'm keeping these individuals safe as well as the whole group context.
>
> L: I wouldn't say I sit down and practice from one theory or from one approach. I think building and drawing out people's strengths will probably be the base of my approach. Whether that could be a CBT group, that can be a DBT group, it could just be an adult support group.
>
> M: I have theories that I generally tend to work with, these are cognitive behavioural therapy, narrative therapy, and ah, emotion focused therapy, for the most part […] So for example I did a lot of group program that specifically focused on narrative therapy […] that's sort of a more formal way of how theory might affect what I'm doing […] informally those theories will affect how I interact with […] participants.

In discussing reflective practices in social work, Napier and Fook (2000) point out that practitioners tend to "separate theory, context and practice" (p. 6). They advocate for students and workers to "become aware of and examine their own espoused theories and to consider these alongside the ideas and suggested action pathways of formal theories […] to examine their own prior learning, the theories they bring to bear 'intuitively' on situations" (ibid.). Analyses in previous sections show that participants seem to construct their practices based on certain understandings of 'eating disorders' that view eating and body image issues as individual pathologies as defined by psycho-medical discourses. As Napier and Fook suggest, these understandings can be viewed as theories that underpin participants' practices, for "theory is implicit in the way people act, and may or may not be congruent with the more formalised theory they believe themselves to be acting upon" (p. 7-8). However, participants do not mention their particular understandings of eating problems as theories that inform their work, suggesting the possibility that in some ways psycho-medical theories and knowledge about eating and body image issues may have been naturalized and taken for granted as truths, which are then re-circulated through practices of psychoeducation.

The participants emphasized that the way psychoeducation was conducted often depended upon the objectives of the groups and the discussions that were brought up by the group members.

> N: What enhances the group is when there's casual psychoeducation […] I've never gone into a group and say that 'we're talking about this tonight,' but when there might be a story in the media that someone brings up […] it happens sort of in a haphazard sort of casual way, such that people don't feel that they're coming to a lecture.
>
> M: So I'm thinking about a group that I ran with um, people experiencing binge eating and emotional eating and over-eating. And ah I presented ideas for intuitive eating, in other words an anti-diet approach. And ah in particular one participant um followed up with me after the group […] to talk about um now knowing the possibility of not dieting […] first time in her life having an alternative to dieting.

However, in discussing psychoeducation, facilitators are also positioned as having specific kinds of knowledge that clients do not have.

> N: The group wouldn't know any difference […] I might talk about attachment, if it came up, and again in a casual psychoeducation. But basically these are kind of the foundation, but most people attending the group would have no idea […] and wouldn't understand that there're actually theories behind it.
>
> M: They don't have background or training in narrative therapy, so I'm not saying to them […] 'get rid of your eating disorder identity' and that, right? […] but there's weekly sessions that would allow them to first understand you know how they might view themselves see themselves with an eating disorder […] So they are going to experience it quite differently than somebody who's got some training in therapy.

Participants' comments are consistent with literature on support groups, which suggests that psychoeducation is a common element in group facilitation (McVey et al., 2003; McVey et al., 2004; McVey et al., 2005; Yager & O'Dea, 2008). As such, these comments reflect discourse of professionalism, which uphold "the belief that professionals are experts who know more than their clients about their problem situation and the means to deal with it" (Fook, 1993, p. 60, cited in Healy, 2000, p. 23). Certainly, in this context, discourse of professionalism also works in tandem with discourse of psychology in creating a binary relationship of power between the client and the facilitator, in which the facilitators are positioned as having the ability and the right to educate due to their access to formalized theories, and the client is constructed as lacking knowledge about their situations and about themselves due to their unfamiliarity with these theories.

"To try and find that true self": Facilitating the awareness and regulation of self and feelings. Participants described supporting participants to gain self-knowledge and awareness about their eating and body image issues.

> N: I would always start off a group by talking that I believe you have your behaviours and your eating disorders for very good reasons. It may not be the healthiest or most functional way but I believe that whatever your reasons are even if you don't know them, they're there for very good reasons. Because I think that most people have judged themselves enough and they don't need that extra judgment.
>
> O: I like art, I like words, I like collages […] I encourage people to express what their scars are trying to tell us […] I often draw kids books into, because I think it really speaks to the person that's inside, because she's usually not very old.
>
> O: It's giving people that courage to try and find that true self […] I'm working on a poem right now, but I only have the first two lines. 'To understand is to stand under, and see the softer side.' And it's kind of directing how I think.

Encouraging self-expression was described as an important part of facilitating self-awareness.

> D: We were there for a whole year and people wouldn't say anything much personal […] but then we started doing the soundscapes [a music-making exercise] then everybody says something […] they talk about where their minds open to […] it could be a past experience or whatever. This has really, um, deepened the sharing or the therapeutic aspects of the group. Um, so I guess I'd be on the lookout for other ways to do that.
>
> O: Sometimes being real feels worse […] And I always say if, if you can't bring it all here and let it hang out, then how do you expect to do it outside of that door. This is a place for corrective experience.

Self-awareness was constructed as involving the recognition of emotions. Several participants defined the lack of emotional recognition as instrumental in the development and maintenance of eating and body image issues.

> N: I would say, 100% of people who come for help around eating disorders, and probably the general public […] but particularly eating disorders, have no idea. They're either numb or if they've had an eating disorder for a long period of time, they either numb by restricting, by overeating, by overeating and purging […] I do an individual practice too […] asking people how they're feeling, they have no, idea.
>
> R: People with eating disorders they have a hard time regulating their emotions, so there are exercises, they are related to mindfulness, where they can sit with their emotions, and wait until they go down to base, because that's what happens to eating disorders, emotions go very high, and it takes maybe a long time to go to base again.

Participants also spoke about the universality of emotions to explain their approaches.

> O: My modality is emotionally focused therapy. I believe in emotions. I believe there is not a lot of space for emotions.
>
> L: I like to use strengths to work through shame and guilt. I think shame and guilt are the core roots for eating disorders, body image issues, whatever it may be. Um and I think that if you have that perspective, you can navigate through all human experiences.

The idea of a "true self" may be related to the western construction of the "self-contained individual" (Guilfoyle, 2001, p. 156), or "the psychological subject" (ibid.). Guilfoyle (2001) explains that this self-contained individual "is assumed to own her or his individual qualities and characteristics" (p. 156). The concept of the self is understood as a social construction that can be traced back to the 15th and 16th century, with the early development of sciences such as biology, medicine, and psychology, and is tied to social practices that focus on the "surveillance of the individual" (p. 157). Psychological and psychiatric discourses thus produce a set of normative standards, ideals according to which people measure, monitor, and regulate themselves. Moulding (2006) further asserts that the concept of the self is built upon gendered and humanist discourses that idealize autonomy, rationality, and self-control, which are culturally associated with masculinity, and define the self as an independent entity that can be affected but is separate from social contexts. In regard to 'eating disorders,' the concept of the self-contained individual thus places the origin of disorder within the person. This individualization of disorder and idealization of control seem to inform R.’s comment about the emotionality of people living with eating problems, how their emotions can “go very high.” Earlier, she has mentioned that her understanding of emotions and emotional regulation in people living with eating problems is informed by theories of dialectical behavioural therapy (DBT). DBT is a model of psychological treatment that is originally formulated to treat borderline personality disorders (Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999), a diagnostic label that is mostly given to women and is constructed based on “criteria that are stereotypically feminine” (Jimenez, 1997, p. 163) and at the same time “delimit appropriate behaviour for women” (ibid.). Thus, it can be argued that in R.’s comment, emotions, especially women’s emotions, are pathologized, reflecting the gendered assumptions of psychological discourse. Poststructural feminist theorists reject this concept of the self-contained individual, and instead argue women’s feelings about eating, the body, and the self are constituted through western cultural discourses that privilege masculinity while devaluing and pathologizing femininity (Bordo, 1993; Malson & Ryan, 2008; Moulding, 2006). Working also from a poststructuralist perspective, Ahmed (2004) theorizes that emotions do not reside within individuals but are produced through interactions between individuals and objects in the world, as well as the histories and social contexts involved in the interactions. The emotion of shame brought up by L. can serve as an important point of analysis in regards to the social construction of eating problems. Ahmed defines shame as a result of the perceived failure to approximate a social ideal, the “affective cost of not following the scripts of normative existence” (p. 107). Social ideals and scripts of normativity are discursively constructed and enacted in social relationships. Drawing on both critical feminist understanding of eating and body image issues and Ahmed’s theorization of shame, it may be possible to argue that shame in the context of eating problems may be associated with women’s perceived failure to approximate a masculinised ideal of autonomy because women are assumed, or even expected, to be passive and dependent — a cultural contradiction known as the “double-bind” of western contemporary femininity (Moulding, 2006, p. 793). Thus, by defining support as practices to help clients develop awareness of the “true self” and regulate their emotions as though they are innate characteristics of pathology, practitioners may overlook the cultural ideals and norms that shape the emotions that are intertwined with eating and body image problems.

Psychology as a discipline is built on people’s recognition of their individuality, providing “a set of techniques and a language through which persons could practise self-government and self-regulation” (p. 157) according to a normative standard. The practices of sharing in groups, or, in O.’s words, “letting it all hang out,” can be understood as a technique of self-governance by revealing one’s thoughts and feelings and making them known to experts who are assumed to understand the complexities of human psychological processes (Guilfoyle, 2001). This assumption is reflected in participants’ generalization that people living with eating problems as well as those without psychological training have “no idea” about how they are feeling, and that psychological understandings or theories of emotions can be universally applied to all who struggle with eating problems, which is indicative of the grand narratives of modernist discourse (Healy, 2000). Furthermore, sharing one’s thoughts and feelings in the group is constructed as an unquestioned good, which can create justification for those in expert positions to intervene in people’s lives and to teach people ‘appropriate’ ways to govern themselves. Naming feelings with “feeling words” was described as one of the ways through which emotions can be recognized and regulated.

> N: I would always encourage people to participate what I call the temperature check in the beginning, and I would go around, and I would always do one at the end as well […] it’s just an opportunity for people to put feeling words, how they’re feeling.
>
> R: And many people just don’t know how they feel […] I also bring a list of emotions. And sometimes I would, when they say ‘okay,’ but what do you mean by okay? Okay, good. Okay, bored. So it’s a lot of working on emotions.
>
> R: The language, ah, I would say like curse words […] Some participants are very, very

> upset, furious about situations, and their emotions go so high that they really want to say all types of, you know, words. The thing is they are not alone during the group setting. So, there we really have to calm down a little bit and try to express their emotions with other words. They're so, their vocabulary is so extensive that they can use other words to express how they feel. Annoyed, furious, betrayed.

Participants described additional ways of providing opportunities for group members to build skills in regulating their emotions in ways that are deemed acceptable in a group setting.

> D: Someone mentioned about anger issues […] we might have a […] little discussion about it, but um, try to relate it to the group (inaudible) skill-building in the group.
>
> R: People can leave the room any time if they feel triggered or overwhelmed, in a quiet way, right? No banging doors. If they, before they escalate they feel very overwhelmed, they are advised to leave the room […] I will ask them, 'are you okay, would you like to go and make yourself a tea in the kitchen.'

It can be argued that saying "curse words" or "banging doors" are also ways of recognizing, expressing, and dealing with emotions. However, these are not expressions of emotions that are constructed as helpful for the clients to achieve self-awareness. As such, practices of support that aim to foster the expressions of emotions may more accurately be understood as practices that promote "western modernity's requirement that individuals be self-governing and self-regulating" (Guilfoyle, 2001, p. 157) in psychological terms, while disqualifying other ways of knowing. Guilfoyle (2001) asserts that this disqualification can be understood as a political strategy that strengthens the institutions of medicine and psychology and privileges psychological practitioners within networks of power relations at the expense of service users' well-being. Moulding (2006) argues that clinical practices that encourage self-regulation actually mirror, and may even reproduce, the self-surveillance and self-discipline that are involved in dieting and weight management practices.

"Being authentic": Characteristics of group facilitators. Authenticity was identified as a valuable quality or character trait that enables group facilitators to provide support.

N: I think being authentic is the most, probably the most important thing, certainly for me

> as a therapist, or as a group facilitator, authenticity is everything.
>
> O: I'm also very real, so if it's not a good day for me, I don't have to pretend that it is. And I'm human, if something's painful, why do I have to pretend that it's not because I'm a professional. So I'm there with you.

Furthermore, participants' approaches to practice were partly constructed through their personal histories or experiences outside of professional practices. L. spoke of her overall approach to working with individuals living with eating and body image issues.

> L: What I first got into the field of wanting to be in eating disorders, it was from young experiences of watching other girls hate themselves […] I was a camp counsellor, hearing the negative self-talk, and it truly just hurt my heart. And I hated that people would ever hate themselves. And I think that that feeling pushed me into this field, and that feeling still is in my practice in trying to get rid of that.

N. and M. described how their own experiences of eating problems and accessing support groups informed their use of psychoeducation in groups.

> N: I'm thoughtful about my self-disclosure […] I think it can be um, move along conversations, it's a way of, again, sometimes minimizing power imbalance but also it's a way of doing some […] casual psychoeducation, about maybe family dynamics.
>
> N: Just being thoughtful it's not about […] the facilitator spend the whole group getting support for themselves, and talking about their experience, and the group may even enjoy it, but something's not quite, not quite right […] But what I found from clients seem to, that helps. It helps to know, it gives some hope […] that there was times my life was, I couldn't, I'd do everything in my life to avoid going to dinner party, and that that ended up one of my favourite things to do, just how things can change.
>
> M: I guess open-ended group or informal support group that I've had attended […] it feels like there's something missing if, um, there's not a little bit of help to get their attention to, um, I guess information sharing, educational pieces […] if the focus is only on people sharing their experiences.

Participants explained that being authentic enabled them to model behaviours that they believed could benefit clients.

> N: So when it comes to support groups again just being an authentic person. So often they haven't had authentic people that they trust […] And that goes for all of us not just for eating disorders […] by being authentic, and by being honest, even if [it means saying] 'I don't feel comfortable answering that,' it's setting, it's modelling. It's really important.
>
> O: The best thing you can do is role model what you're saying. And sometimes that's

> really hard […] so it's always bringing up the unspoken I think that's really what I'm trying to do. Speak the unspeakable.

Particularly, N. and L. spoke about demonstrating ways to deal with differences or conflicts.

> N: People with eating disorders, and not just people with eating disorders, women in particular I would say, struggle with having a difference of opinion […] And I thought, well, we won't go out of our way to find differences of opinion, but when we do, let's use that, so that people can learn to appreciate […] And um, again, it's about being authentic. You know it's not creating any situation but it's showing that yeah you can have differences with your co-facilitator you can have totally different personality.
>
> L: Having just really honest conversations […] Staying calm, staying neutral […] I think it's nice teaching moment, ah conflict is going to happen everywhere in everyone's life. Ah conflicts happen all over the place, so I think people learning from the facilitator on how to work through conflicts is helpful, and you learn skills in that […] we need to be giving practice skills, so I think people can learn from that from one another.

In discussing authenticity participants seem to indicate a blurring of the boundaries between the practitioner and the client. For example, O. spoke of experiencing and expressing emotions alongside her clients, and other participants described their own past experiences of eating and body image issues. As such, participants' discussions of authenticity seem to reflect the concept of egalitarian practices in activist social work discourse, which has "the goal of fostering equity between workers and participants within the context of practice" (Healy, 2000, p. 28). Indeed, N. specifically speaks of authenticity as a way to "minimize power imbalance" between practitioner and client. However, in some ways participants' discussion of authenticity may reinscribe the dichotomy between facilitators and clients. In their narratives about their personal experiences of eating problems they are positioned as having overcome their difficulties, no longer struggling, and having specific insights and knowledge about eating problems, in contrast with the clients, who are positioned as actively struggling and in need of education about their problems. Personal experiences and authenticity are thus constructed as a tool to educate the clients, to "model" behaviours that are deemed 'healthy' or 'appropriate.' This seems to reflect the psycho-medical discourse of 'eating disorder,' built on the legacy of Bruch's theory of anorexia nervosa, in which "the anorexic woman or girl is understood as lacking authentic autonomy" (Moulding, 2006, p. 794). The modelling of authenticity as a practice of support thus reinforces the dichotomy not only between practitioner and client but also between normal and pathological. Surtee (2009) reflects on her role as a nurse in a treatment facility for eating problems and describes the power relations between practitioner and client in psychological and modernist discourses as a binary between "professionalized One and pathologized Other" (p. 164). She further explains that "much clinical work involves striving to maintain distinct psychological and physical dualism between the two. We do this consciously, in our talking, body language, communications and writing with patients […] to model the differences between 'not-normal and 'normal' eating, thinking, and feeling" (p. 164). Authenticity may then be understood as part of the normative standards of the psychological self as explained by Guilfoyle (2001), which, in N.'s comment, may once again be tied to the idea of autonomy, when she relates being authentic to having and expressing "a difference of opinion" rather than agreeing with others. The practices that encourage clients to express themselves authentically may therefore contradict with practices that promote the self-regulation of emotions and emotional expressions. On the one hand, clients are encouraged to be aware of how they 'truly' feel and express their thoughts and feelings in authentic ways independent of others; on the other hand, they are advised to follow rules, to filter their words, to use only 'appropriate' words to express how they feel, to suppress intense feelings with self-regulating practices. However, O.'s comment about how difficult it is to role model her own advice, to live out her ideals, seems to create an opening to disrupt the dichotomy between the normalized practitioner and the not-normal client, to understand that categorizations and dichotomies are unstable, subjectivities and subject positions are fluid and not fixed, thereby disrupting also the operation of power that underlies the facilitator-client relationship within the psychological discourse (Healy, 2000).

"It's really a construction": Incorporating social and cultural aspects of eating

problems. Specific interview questions were asked about whether participants take into account issues of social inequalities, such as gender inequalities, when facilitating support groups. In response, participants spoke about societal pressures for women to be thin.

> R: This is a cultural phenomenon that is happening at this time and point in history, hasn't been this way at other times. So it's really a construction. It's not been that way forever, since humanity started. So that's one thing we covered and also what's also considered it's a way of control, also, to make people buy certain things, so consumerism is involved […] oppression, to women, there are so many types of oppression, I think that's one type, right? […] and also I'm originally from a country that has a really, really high prevalence of eating disorders […] Well the thing is the financial situation of my country has been very unstable. So it was a way for people especially for women to have control over something. And political instability as well […] they might not control how much money they can make, they can control how, or they think they can control how their body looks like.

While participants shared that, to varying degrees, they did incorporate social and cultural issues into discussion in groups, they also described limiting the amount of time spent on these issues, in accordance with the interests of the clients.

> M: So again it depends on the focus of the group, what the group needs that sort of ideas, but I do try and incorporate some ways for people to recognize that the social and cultural ideas that have affected, ah, either their developing or their maintaining of an eating disorder. And that's in part help alleviate shame, for one, but two to recognize that, um, some of the symptoms […] some of the behaviours, some of the underlying feelings, are, in part at least, there, because of the social and cultural contexts we live in […] In one group, the narrative therapy one I think […] one of the weekly activity is about finding some messages in our […] social and media, day to day activity […] where they can clearly, critically analyze how social cultural ideas impose on us in terms of the views of our bodies, eating and dieting […] having questions to the group, in particular looking at some cultural assumptions.
>
> O: Yes, but there are veterans in the eating disorder world that are clients, it depends on where your group's at. If I have a lot of veterans, they already know all this […] They know lots about eating disorders. So we will touch on societal and media and gender for sure, but it's really what they need to talk about.
>
> R: I will give it the time, we'll discuss, and also try to ask participants what can we do, not only complaining or expressing concern about it, because […] people feel like they lose hope, then nothing can be done. So I try to point it to what can we do from our space […] and then we move to the next topic, right? Because I don't want to dwell in something where people don't think they can change the whole picture, which is difficult.

R.'s comment about eating and body image issues as a construction echoes Bordo's (2009) theorization that eating and body image issues are tied to the western consumerist culture and male-oriented sexualized ideals. In this sense both R.'s and M.'s comments also seem to challenge the psychological discourse and reflect poststructuralist and social work discourses in situating eating and body image problems in specific cultural contexts that can shift (Healy, 2000). Consistent with literature on support groups, other participants also acknowledge the contribution of social and cultural messages in the development and maintenance of eating problems and describe ways to address these messages to varying degrees (McVey et al., 2003; McVey et al., 2004; Yager & O'Dea, 2008). In the participants' descriptions, discussions about social and cultural norms are treated as topics that are contained within a specified amount of time in the group sessions, separate from other topics of discussions in the group, such as issues of emotions and the self, which the participants have emphasized when discussing their practices of support. Writing from a poststructuralist perspective, Malson (2009) cautions that "'anorexic' and 'bulimic' subjectivities, experiences and practices cannot be adequately understood *only* in terms of a hyper-conformity to a culturally dominant, media-promulgated idealisation of female slenderness and that culture's culpability in the production of eating dis/orders is considerably more far-reaching and complex" (p. 136, author's emphasis). Elsewhere Malson and Burns (2009) use the slash between 'dis' and 'order' to disrupt and show as illusory the categorical divide between the normal and the pathological, thus advocating that individual experiences of disorder and distress are "part and parcel of the (culturally normative) order of things" (p. 2). In this postmodernist understanding, emotions and the self are not outside of the socially and culturally normative order of things that give shape to eating and body image problems. The participants' comments about separating social and cultural issues from other topics of discussions, including emotions and the self, thus point to a "humanist discourse, which maintains a separation between individual and social aspects of phenomena" (Moulding & Hepworth, 2001, p. 309). Moulding and Hepworth (2001) further explain that this separation is “often referred to as ‘individual-society dualism,’ where society’s norms and values are seen as internalized by individuals but the individual is understood to be, at the same time, separate from the socializing effects of the wider collective” (p. 309). In contrast, poststructuralists argue that anxieties about food consumption and the fear or even hatred of fatness are rooted in specific historical and cultural contexts with moral, religious, and economic implications (Malson et al., 2007; Sayers, 2009), thereby theorizing that the individual and society are mutually constitutive. R. reasons that she limits the time spent on discussing social and cultural issues because “people don’t think they can change the whole picture.” This reflects a structuralist understanding that in order to create change oppressive social structures, such as the media, need to be completely overthrown (Healy, 2000). However, if individuals can explore how the social orders that constitute eating and body image issues, not only media messages of beauty, dieting and the body but also broader social norms such as gendered binaries of reason/irrationality and normal/pathology, are also at work in shaping individuals’ emotions and perceptions of the self, then perhaps some possibilities can be created for people to resist these norms in everyday, localized contexts (ibid.).

Figure 2. D.'s artwork.

"What I had in mind was a drum circ, head of a drum […] so the inner colours are the drum circle. The white part is the head of the drum […] I put the supporting concepts, kind of, principles outside, like what I'm hoping to bring to the group. So challenge, welcome, like the stories from the generations, the rhythms from the generations. Um, culture, um, fresh approach. Um, we do the soundscapes, so sounds, sights, and ah, sense of celebration, present and past. And then what I put in the middle was, um, what I hope individuals take away for themselves from the group, so power, joy, potentials, feeling like they have a chance to express themselves and a sense of freedom." – D.

Support as Creating Space for Others' Knowledge

While participants emphasized the use of predetermined group structure and guidelines to maintain a sense of emotional safety, when discussing what they meant by providing support they also stressed the importance of being "flexible" in their approaches and modifying their practices according to the needs and interests of group members. They also described practices that created opportunities or even expectations for group members to contribute to the supportive environment by taking on leadership and responsibilities in the group. Discussing the limitations of their roles as group facilitators, participants expressed their desire for group members to find support outside of the client-facilitator relationship.

"You have to just be where the clients are at": Facilitators learning from group members. Participants described that part of providing support had to do with being flexible in regards to the agenda or the focus of the group sessions, adjusting their approach to support according to the needs, interests, and characteristics of the group members.

> L: I think being a facilitator in providing support you have to just be where the clients are at. So going in as a facilitator you can't go in with your own agenda, um, or thoughts of where the group is going to go. You may go in thinking okay here are a couple topics or discussions, but I think that the support is where everybody is at and respecting where they're at […] it's just providing the foundation of respect to be there.
>
> A: I always gave […] the option of accountability. If this is your only support, is there anything that you need us to check in with you about next week […] and sort of say 'yes I need to make sure that I focus on self care' or, giving people that opportunity to say, 'okay, let's focus on it then.'
>
> M: I did have a group once, it was very small, there was only 4 participants, all the four were kind of quiet and withdrawn, so I'm going to have a very different approach with that group compared to a previous group where there were four very eager, talkative, willing, participants. So if I go in with a certain agenda and it's not working for that group, then I want to be flexible to alter things as I go. So that's what I mean by trial and error.

Indeed, participants explicitly described a sense of uncertainty in what might result from the group session or their facilitation practices. When asked to talk about a time when her approach made a difference for a group member, O replied:

> O: You wouldn't necessarily know. When I think I'm amazing and outstanding, no one else does. It's the things that I didn't notice (laughs) that I wasn't even trying, that make a difference.

L. conveyed in her artwork a similar sense of not-knowing in regards to how group members may experience the support groups.

> L: At the top I have unexpected. Support group, what I have learned as a facilitator is you never know what's going to happen, um and I think the clients don't know what's going to happen, whether it's them with other people, or them with themselves.

This sense of uncertainty regarding the process and the outcomes of the group seems to contradict earlier comments that reflect the claims of professional and psychological discourses, which assume that those in professional or expert positions have the knowledge to resolve clients' problems (Healy, 2000). Instead, it evokes the ideas of client-centred practices, "power-sharing and client leadership" (Healy, 2000, p. 29) that are promoted in the activist social work discourse, which aims to challenge systemic oppressions, including those that play out within client-worker relationships. A. described attempting to convey to group members her openness to changing the ways she facilitated the group according to their feedback.

> A: I think I'm pretty approachable, so I really encourage people to say something wasn't right, like email after and I will try to make an adjustment if something upsets you.

Indeed, participants attributed their knowledge about group facilitation to their clients in the group. When asked about what led her to her understanding of support, O. replied:

> O: This amount of years I've been doing it. Seeing people that have relapsed a lot, actually get better.

Participants also described learning from the group members especially in regards to identifying practices that seemed ineffective.

> O: I would say I've learned as much from group members as I have from my training. But you get a lot of anger. You hear through the grapevine […] that someone's pissed off about your group style.

> A: Because I was, my role at [agency] as the program director, you get all of the people that are unhappy with something, right? So they come to you and say, "I was in this support group and so-and-so was leading it and she did this and it really upsets me and, she shouldn't be doing this and, I don't like this" and so, kind of taking that into account and saying, okay, this is what works and this is what doesn't work.

A. described making changes to her practice approach because clients were "unhappy" with the services they received. She does not mention reflecting on the effects of her approach on clients' mental health, which is ultimately the focus of the support groups. Arguably clients can feel unhappy when practitioners bring up or challenge them about issues that are important to them, but it does not necessarily mean that discussing the issues is unhelpful. In fact, O. has commented that in the group "definitely people cannot expect to feel better," because they are asked to be in touch with their thoughts and feelings, which are not always pleasant. As such, while this flexible way of practicing seems to reflect a client-centred approach, it can also be an effect of the neoliberal discourse and related to organizational practices in the social service sector. In a neoliberal political climate where funding for social services is scarce and often based on "result-based accountability requirements" (Gibson, O'Donnell & Rideout, 2007), client satisfaction is key in maintaining group attendance, ensuring positive client feedback, validating program effectiveness, and strengthening the reputation of the organization.

Specifically, L. described the necessity and importance of consulting with men in the development of men's support groups due to her own subject position as a woman.

> L: We are doing the first men's support group right now, we've never run that before. Um, and before doing it we held a focus group, 'cause at the end of the day, say myself, a young, privileged, white woman, doesn't know the lived experiences of men living with eating disorders. So we had the focus group, we learned from them, what are you hearing, what are you experiencing with doctors, at work, in school, to put that into place so that we can have a group that makes sense.

L.'s comment challenges the prevailing assumption that eating and body image issues are women's problems by learning from men's experiences of these issues. Such assumption reinforces the gendered binary within psychological discourse that positions men as inherently rational and cannot possibly have difficulties with such basic survival task as eating (Hepworth, 1999). It continues to create tremendous difficulties for men to seek support (Robinson, Mountford & Sperlinger, 2013). L.'s challenge to this assumption can therefore be viewed as an important step in disrupting the claim of gender neutrality and objectivity of psychiatric discourse and the authority of gender and psychiatric discourses in defining eating and body image issues. At the same time, Scott (1992) warns that using individuals' experience as the starting point to explain and understand the problems of a specific population group can risk producing essentialized categories of people. Indeed, Boler (1999) suggests that "in the process of 'understanding' we desire to 'simplify'" (p. 200). It is not the aim of this analysis to negate the importance of learning from men in order to develop relevant practices of support. Rather, it hopes to reiterate that service providers' practices are not outside of dominant, modernist discourses and the longstanding western philosophical tradition to create the illusion of certainty by "reducing the flux and heterogeneity of the human and physical worlds into binary and supposedly natural oppositions" (Flax, 1992, p. 453). In regards to men living with eating problems, there lies the risk of naturalizing the binary of men verses women in terms of the differences in their experiences and 'symptoms of eating disorders' simply based on gender differences, while precluding an examination of the histories, social contexts, and gendered norms from which definitions and experiences of 'eating disorder symptoms' have emerged.

"We share leadership": Encouraging clients to support, lead, and take responsibilities. When describing the meanings of support in support groups participants emphasized group members supporting and sharing knowledge with each other.

> A: I think there are skills that are shared and learned in support groups too, right? 'Hey this is what works for me, why don't you try this' kind of thing.

> R: The thing is some people don't feel well but when they can help somebody else, they give some feedback, some support, they feel, oh, 'I'm doing something.' And then saying 'well maybe I'm not feeling well right now, but I see this person and she's getting better,' so there's hope.

Sharing leadership with group members and encouraging them to take on responsibilities were also constructed as a part of support.

> D: We share leadership. Group members take the leadership on various activities, like soundscapes for instance.
>
> N: Once [we] have a few regulars, I would say, 'okay, what am I forgetting' […] and she would talk, and so we get to the point where, of course we all remember things better if we teach. And so that other people in the group would go over why we don't focus on eating disorder behaviours for example […] it wasn't always the facilitator giving that information, that the focus was really on, um, encouraging the members to take responsibility. And also to feel that it's a really fair group.

The idea of client leadership reflects the activist social work discourse in challenging power inequalities between client and professional (Healy, 2000). However, in the participants' comments client leadership is delineated within the structures and rules that are already defined by the facilitators, which are shaped by the broader psychological discourse and understanding about eating and body image problems, as N. describes teaching group members to "go over why we don't focus on eating behaviours." In this way, power operates through anti-oppressive practices to regulate individuals' thoughts and behaviours according to the terms of psychological discourse. Furthermore, part of support was making clear the expectation for group members to take personal responsibility of what they wanted to gain from the group.

> O: I show up, I'm ready to be there for you, and I need you to show up with what you need to get out.
>
> A: Emphasizing the fact that this is for them, right? That this is a support group setting and I'm not a therapist sitting in the front of the room telling them exactly what they have to do. I want them to be able to make those decisions for themselves.
>
> R: The participants are responsible for the wellness of self, right? […] They decide if the group is good for them or not, if they're ready […] I really highlight in every group if they feel triggered or too overwhelmed, they can leave the group at any time […] and sometimes they are triggered, but they told me that they'd rather stay and learn than leave.

> And I have told them that's okay, but as long as they know that that's your responsibility. If you feel you can take it, of course. We can say, [agency] is not a crisis centre, so that's another thing that we explain to them.

The emphasis of individual responsibility reflects a neoliberal discourse, in which responsibilities for health are downloaded onto individual service users (Gibson et al., 2007; Malson et al., 2007). As explained in R.'s comment, clients are responsible for removing themselves from the group and taking care of themselves when they "feel triggered," but there is no mention of working with the group members to address how the overwhelming emotions are triggered in the group context. The concept of individual responsibility also reflects the humanist and psychological discourses, which view the individual as separate from the social world; emotions are therefore thought of as residing within the individual and owned by the individual (Ahmed, 2004; Moulding, 2006). This may prevent critical reflections on the part of the facilitators in terms of how the issues, interactions, and practices in the group may have contributed to the clients feeling "triggered."

Participants also spoke about how group members supported each other. In describing her observation of this mutual support, R. also explained the limitations of her role as an individual practitioner.

> R: Not just my approach […] It's my approach, and at the same time I think if there's another facilitator doing the similar, it doesn't have to be the same, it's the group that is helping the participants, it's not particularly me.

> R: When they have an individual therapist they can only hear one perspective. In a group there's a variety, that's the beauty of group, they can hear a variety of perspectives, some are opposite and some complement each other, right? So they get to choose from all those ideas and maybe from different ones from what they really want.

When asked about a time that her approach to support made a difference for someone, L. described this interaction in the group:

> L: She sat there and she looked like she sort of had some tears forming when she came into group, and the woman said 'you look upset today, are you okay.' And it wasn't me, it wasn't a professional in the room having to get her to draw her emotion out or share what she was experiencing, it was somebody who has sort of walked a similar life's path, and

> they had shared experiences, and they just didn't know it yet. So her asking all of a sudden created a space.

Particularly, N. described drawing from feminist therapy to address relations of power between facilitator and group members.

> N: It would be about minimizing power imbalance […] and again back to the importance of furniture. Ideally, and it doesn't always work out this way, but people sitting at similar level […] I believe that particularly people with eating disorders struggle with feeling empowered or low self-esteem. So it's important to through language, through how people sit […] I've always felt strongly about people calling me by my first name, if I'm going to call them by their first name.
>
> N: Um, language […] I would refer to women as women, as opposed to girls […] I would encourage them [group members] you know, again just sort of casual psychoeducation about, you know people often struggle with growing up, or struggle with feeling empowered, what is being a woman versus being a girl?

The participants seem to reflect ideas of feminist discourse, which involves "an emphasis on women's, rather than professional, knowledge and participation" (Moulding & Hepworth, 2001, p. 315). N. specifically described practices to create space for women to feel empowered. Yet, paradoxically, in her comment the concept of empowerment is again built on the positioning of people living with eating problems as in need of education. This construction of empowerment resembles the concept of consciousness-raising based in activist social work discourse, which Healy (2000) has critiqued as a practice that can reinforce the grand narratives and truth claims of modernity in delineating for clients 'correct' ways of thinking and speaking to challenge dominant culture, thereby overlooking and subjugating alternative ways of resisting domination.

"I don't want people to just be able to talk to me": Facilitating support outside of client-facilitator relationship. For the participants, part of providing support was about facilitating connections with other sources of support outside of the group and the client-facilitator relationship.

> O: I'm a systems thinker, give me as many part of the systems as you can, I don't want people to just be able to talk to me, because relapse is the fact that you go out there in the

> world and no one else can get it. I want to give you the tools and the other people in your life to get it.
>
> D: I guess [the drumming group] is kind of, somewhat contained atmosphere, right? […] So it's like to take either skill or love of rhythm or whatever and their self-confidence or knowledge […] take that into other things that they are doing in the community.

O. and R. linked the need for additional support outside of the client-facilitator relationship to their understanding of the characteristics of people living with eating and body image issues.

> O: I also believe in art, and believe in hobbies. When you remove this huge part of your world [eating problems], what's going to fill up the new space. And unfortunately it's usually something else negative.
>
> R: What I don't really want is people depending on one person, which is me. I believe that other facilitators can do as well as I do […] that's the thing, many people with eating disorders, they have this, they build this bond and sometimes they can get too attached to one person. So that's another thing that I tell them, hopefully I'll stay facilitating the group for as long as I can, but if somebody else is in my place, what they need to remember is the strength and the ideas and the strategies is in the group.

Thus, though O. saw decreased group attendance when she involved students in the group, she emphasized the importance of sharing knowledge with other professionals to continue the work.

> O: I'm trying to help people be able to […] learn from my 15 years, right? So we can all do this work […] We're all trying to figure this out together, so generosity […] people have been generous to me, I didn't get here by myself.

When O. speaks about her desire to give clients the tools so that other people in their lives would "get it," what does "it" mean? What kind of knowledge is reproduced when she shares her understandings with students, other professionals, and clients? What kind of knowledge is reproduced about people living with eating and body image problems through practices of support? In this section participants have de-emphasized their own professional contribution to support by emphasizing support outside of the client-facilitator relationship. Outside support and increased resources can certainly be important and beneficial. What might be concerning is that the need for outside support seems to be constructed through essentialized ideas about people living with eating and body image issues. In R.'s comment, clients' attachment to the group facilitator necessitates the development of other supportive relationships in the group; this attachment is characterized as a sign of ‘eating disorder’ pathology, in line with “Psychodynamic explanations of eating disorders” (Moulding, 2006, p. 794) that “pathologise characteristics such as connected-ness and emotionality typically associated with the ‘feminine’” (ibid.). For O., the belief that art and hobbies are helpful is formed on the basis that people will engage in “something else negative” if they are no longer concerned with eating and body image issues. This may be pointing to the inherent, and therefore unchangeable, irrationality that characterize women with ‘eating disorders’ in gendered and psychological discourses. As such, essentialized and pathologizing ideas about people, especially women, living with eating and body image issues may be reproduced through practices that aim to expand and enhance resources for them. Epston and Maisel (2009) argue that psychological and medical discourses invite individuals into subject positions that situate ‘eating disorders’ as “something ‘within’ themselves, something that they ‘have’ or ‘are’” (p. 213), thus rendering change difficult. Indeed, in a recent study conducted by Malson et al. (2011), women in treatment have shared that, due to this deficit view of themselves as “essentially anorexic/bulimic” (p. 30), they have found recovery from eating difficulties to be “unimaginable” (p. 29).

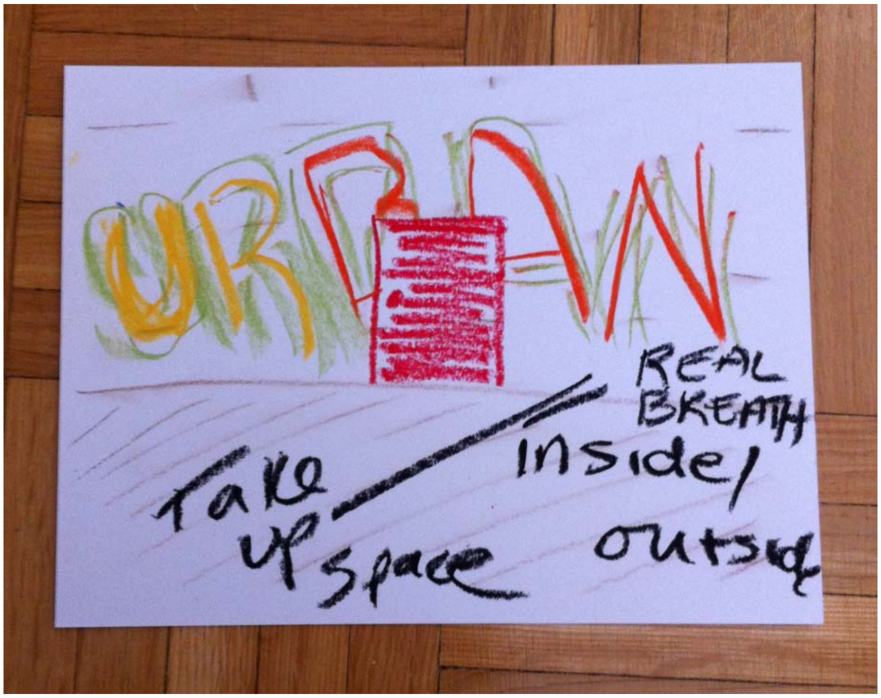

Figure 3. O.'s artwork.

"I would have to say that it's kind of like a portal. And it's a very rushed vision of an urban wall, with graffiti, and it's like, it can be kind of a busy, dirty, frantic time, and no one has time, and everyone's always in a rush, there's isolation on my wall, and you walk in a door that you're not sure if you want to open because there's not a lot of signage, you don't know what to expect. And when you come through the door, you're not blown away by the surroundings, because we don't really have time in this busy world to make that room look like the perfect group room. But you can sit back, take a deep breath, take up space, be heard. And you know that when you walk out of that door maybe you have to staple it and wrap it all back up again, and go on through your day and be an adult, but every Monday from 3 to 4:30 there's a place where you can come, and you can be real." – O.

Support as Facilitating Connections

In discussing the dynamics that they had observed in support groups, participants described practices that they used to facilitate connections within the groups, which they perceived as beneficial for the group members. Not surprisingly, shared experiences of eating and body image problems and the shared objectives of mitigating these problems were understood by the participants as important points of connections that could foster mutual support amongst group members. The importance of facilitating connections seems to be constructed upon the understanding that people living with eating and body image problems often feel isolated. At the same time, participants also described support as giving explicit “permission” for varying degrees of connections and participation, from sitting silently in the group for weeks to building friendships beyond the group meetings. On the other hand, participants also described different kinds of disconnection that may threaten the development of connections within the groups, such as conflicts, clients’ lack of readiness for change, and clients’ other mental health issues.

“They’re not alone”: Facilitating connections over shared experiences. In describing their approach to support, participants spoke about their attempts and desire to facilitate connections amongst group members. Safety, which is constructed through particular rules, expectations, and group structure as discussed earlier, is often mentioned as a prerequisite for relationship-building and sharing between group members.

> L: And if you can foster an environment of respect and safety, you open the door for people to share lived experiences, share really challenging emotions, share a lot of fear, and then turning that into something that you can grow from.
>
> D: As group facilitators we would prepare the overall structure, but we’d encourage group members to relate to each other, to comment on, you know to speak about each others’ music or poetry or what they’ve said […] trying to encourage women not to feel alone, to feel connected.

The importance of safety is therefore built on the belief that it can encourage clients to openly share their often difficult experiences and emotions in the group, which is in turn built on participants' understanding of the linkages between experiences of isolation and eating and body image issues.

> A: Just really for once feeling heard and supported I think it's really important. I think that if you can get people to attend these groups, the fact that this illness is so isolating, um, it's quite amazing to see how it can be helpful.
>
> L: Maybe they just make eye contact, and they don't know how to do that ordinarily, maybe they use one another's name, maybe they ask how their child's doing […] You just see how much people care for one another. And for a population of people that you think you know sometimes lack social skills or being isolated because of how they feel about themselves or their relationships with food, the human experience doesn't really change […] Everyone still wants love, support and acceptance. And if you don't get that in other areas of life, the fact that you get that in a support group I think is, I think it's magical sometimes.

L. gave an example of a client, which further explained her understanding of how isolation may result from eating problems, and how making connections in the group reduced isolation.

> L: I'm just thinking of the one new group I started this winter season, one young woman came into it, didn't speak the first two weeks, um, always sat there very visibly upset […] Until I think eventually she broke down and started talking. Um and I think she took that step because there wasn't any other outlet for her […] Lost her family because of her relationship with food, lost her friends because she has isolated herself. So she came because at the end of the day that support group was going to be the only space that would listen […] You know last week at the end of the group she was exchanging phone numbers with group members on the front porch. She had made friends, she had found someone to trust. She didn't have that before coming into that room and doing a support group. Um, I think she found her voice.

It can be argued that isolation is referred to as a "fact" of 'eating disorders' in the participants' comments. This may reflect the discourses of psychology and psychiatry that position individuals living with eating and body image concerns as lacking social skills and self-isolating. For example, Choat (2010) describes a model of "interpersonal group therapy for women experiencing bulimia" (p. 349), which is built on clinical literature asserting that these women "typically exhibit a number of peer, family, or marital relational problems, including conflict avoidance, perfectionism, difficulties with role expectations, fear of rejection, deficits in social problem solving, and lack of perceived social support" (p. 351). As such, relationship challenges are individualized and pathologized as characteristics of 'eating disorders' and 'deficits' inherent in the individuals, especially women. Gender as well as neoliberal discourses may have shaped the participants' comments about isolation and eating problems, in which isolation is constructed as a problem of the client's own doing. In L.'s comment, the client is positioned as the one who has lost her family and friends because "she has isolated herself." This understanding of self-imposed isolation can conceal the discourse of sanism, defined by Morrow (2013) as "the ways in which diagnoses and labels of mental illness result in stigma and discrimination and constitute a form of inequity" (p. 327). In a recent study by Linville, Brown, Sturm, and McDougal (2012), young women who have experienced eating and body image problems report that they frequently experience rejections from family and friends, who have distanced themselves from the young women because 'they could not 'deal' with the eating disorder" (p. 223). The young women also recall keeping "others at a distance as a way to protect themselves from the negativity they experienced from others" (ibid.), including criticism based on stereotypes that associate eating and body image issues with "getting attention, vanity, or selfishness" (ibid.). Thus, while individuals may indeed distance themselves from others because of their eating and body image problems, this distancing can be a response to being rejected, alienated, and cast out of belonging by others because of popular assumptions about 'eating disorders,' shaped by the dominant discourse of sanism that discriminates against those who are deemed irrational or 'insane.' Furthermore, through research a close link has long been established between abuse, sexual violence, trauma, and difficulties with eating and body image (Hepworth, 1999). Burstow (2003) argues that for individuals who have experienced violence and trauma, "the world is not a safe and benign place, and so mistrust is appropriate" (p. 1298). Participants did not explicitly speak about working with women who have experienced abuse, but consideration of the close link between trauma and eating problems, as well as an understanding of sanism, can provide another opening to bring in an awareness of social contexts in challenging the taken-for-granted, medicalized belief that "interpersonal deficits" (Choat, 2010, p. 359) such as self-isolation and the inability to connect with and trust others are results of individual psychology.

L. suggested that clients were able to experience "love, support and acceptance" in the support groups with others who also experience eating and body image problems. Reduction in isolation and relationship-building are therefore related to the practices of support that aim to facilitate the recognition and sharing of similar struggles. This emphasis on shared experiences of eating and body image issues is consistent with literature on support groups (Choat, 2010; Harper & Shillito, 1991; Staples & Schwartz, 1990; Wanlass et al., 2005; Weber et al., 2006).

> O: I believe in groups, I think a group is way more powerful than seeing me one-on-one […] Because there's nothing like seeing other people going through the same thing. And I honestly believe if we all throw our problems in the middle of the room, we'll pick our problems back up again […] it's like the normalization of it.

When asked about the words or images that came to mind if she were to consider the kind of support that she wished to facilitate in a support group, M. shared the words "warmth, understanding, comfort, similarity, I'm not alone, I'm understood." When asked how these experiences would be facilitated, she explained:

> M: I think one of the things is um having people, giving people the opportunity to share their personal experience. To allow people to find their similarity, um, in terms of learning that other people may be experiencing something similar, and that they're not alone, which can offer some comfort.

A. explained how group members were able to support a transgender individual by building connections over shared experiences of eating and body image issues.

> A: You're looking at someone and they're opening up about something so serious and so personal and something they probably can't relate to at all, but the other side of it is, they have so many things that they can relate to, right? Their experiences aside from that are very similar, the feelings are the same, and the challenges are the same.

Morrow (2013) writes that people from disenfranchised groups “all experience stigma and discrimination differently, in ways that compound their experiences of mental distress” (p. 326). The experience of eating and body image issues of a trans woman can therefore significantly differ from the experience of eating and body image issues of a cisgender woman because of the extreme marginalization and violence that trans people face in our heterosexist society. The highlighting of similarities or even sameness in individuals’ experience of eating and body image issues thus reflects a biomedical discourse, which defines ‘illness’ as neutral, objective entities that affect everybody in the same ways, regardless of their personal histories and social positioning. The notion of empathy may also play a part in participants’ comments about the importance of shared experiences. Boler (1999) theorizes that “[in] popular and philosophical conceptions, empathy requires identification. I take up your perspective, and claim that I can know your experience through mine” (p. 160); the story of the other is therefore subsumed under and subjugated by one’s own story in the process of exercising empathic identification. The assumption of sameness can subsume the different meanings that people give to their eating-related practices and body image concerns under a set of seemingly objective symptoms and characteristics of ‘eating disorders.’ Defining the sharing of similar or the same experiences as the basis of support thus not only risk rendering invisible the racialized, classed, gendered, and heterosexual social norms that give rise to eating and body image concerns in the first place (Gremillion, 2003; Nasser & Malson, 2009; Saukko, 2009), it may also lead clients to construct their own experiences in ways that fit with psycho-medical definitions of ‘eating disorders’ in order to fit in within the group, to experience a sense of belonging, to receive love, support, and acceptance (Guilfoyle, 2001; Koski, 2014). The power of psychological, psychiatric, and biomedical discourses thus operates through the desire for support and acceptance, as well as the desire to provide support, to regulate professional as well as client understandings of eating problems, thus maintaining their domination in defining social reality (Guilfoyle, 2001; LeBesco, 2009). Indeed, O. pointed out that sharing similar experiences of eating and body images can also have adverse effects on group members.

> O: I mean one thing I found alarming is the fact that this whole body image, positive health body image movement has actually been, um, detrimental in university, college, in high schools […] it encouraged girls that didn't maybe know too much about eating disorders […] So sometimes a group can make someone worse. A contagion.

The pathologizing language that is circulated in support groups for eating and body image issues and in people's every day interactions thus invites people to take up certain subject positions that are defined by the psychological discourse. As Koski (2014) suggests, concepts of illness that defines the illness as rooted in the self and therefore chronic and unchangeable can lead to increased distress and poor health outcomes. The widespread circulation and acceptance of psychological definitions of 'eating disorders' can also broaden "the range of individuals who can and do identify as having an eating disorder" (p. 86), thus furthering the medicalization of experiences that are discursively constructed through cultural norms and practices.

Furthermore, the positive outcomes that participants saw or hoped for in facilitating connections were often described not only as friendship but also as loving, familial relationships.

> D: It was amazing with how the group members gave to each other too […] the words mothers and daughters and friends. It's nice.

> O: The university and college support group that I ran at [agency] there was a core of about 10 girls that all ended up being in each others' weddings, and ah, it felt like a family.

> R: I just remember one that, ah, has gone through a very rough period, and the support from the group and the concern that the participant felt, that was what they say, there was so much love here. I always hope that, not always, but many times it's tough love (laughs). Just to hear, that's what I try to tell, but sometimes people they don't want to hear […] but I feel that they're open to hear it, and at least to consider, right?

> O: There's a lot of acceptance, it's very relational […] I do see it as a recapitulation of your family of origin.

L. described her artwork in a similar way:

> L: I put a little wolf and its baby, um, for love […] and I think love in that actual picture, it's the closeness, the connection, and it kind of made me feel almost how birds feed their

> young. So, um, nourishment, and that can be nourishment by food, or nourishment by just connections and touch and support.

Gremillion (2003) argues that, in the area of eating difficulties, traditional treatment's "attempts to transform familial relationships through the provision of a substitute family hyperbolize dominant constructions of 'ideal' families – and of motherhood in particular" (p. 74). As systems theory and various models of family therapy have informed social work and counselling practices today (Healy, 2005), it is perhaps not surprising that the discourse of family may also be at work in participants' constructions of support. Indeed, O. explicitly defines the support group as "a recapitulation of your [clients'] family of origin," and L. constructs the idea of love through imageries of the ways animals "feed their young." Gremillion (2003) situates discourse of family in a specific historical context by pointing out that the industrial revolution and its resulting social unrest has led to dominant description of the family as a "natural 'haven in a heartless world' and the primary environment for creating individuals who will be capable of leaving the nest" (p. 75). Treatment for eating difficulties is often likened to parenting, which is thought to displace or at least supplement the 'dysfunctional' family relationships that are presumably the cause of 'eating disorders' (Malson & Ryan, 2008). In studies of treatment programs for eating difficulties, a "therapeutic family" (Gremillion, 2003, p. 199) is constructed by female practitioners as involving "offering 'a lot of love'" (Malson & Ryan, 2008, p. 123) as well as establishing "clear boundaries" (Gremillion, 2003, p. 76) and disciplinary practices to support clients' development of autonomy and to combat the "perceived overprotective, domestic 'enmeshment'" (ibid.) in the clients' own familial relationships especially with their mothers. While participants do not explicitly describe themselves as parental figures within the groups, their comments about family are reminiscent of the link between therapeutic relationships and ideals of family in that seemingly unconditional acceptance and nurturance are balanced by "tough love," conceptualized by R. as encouragement for clients to make choices that they do not like but are good for them. Gremillion (2003) drew on the work of Salvador Minuchin, "the central figure in the formation of (structural) family therapy for anorexia in the 1970s" (p. 175), to explain that definitions of functional and dysfunctional families in therapy relied heavily on cultural constructions of class and race. His solutions for 'disorganized' families were based on a Eurocentric model of nuclear family and middle-class assumptions about "'proper' family organization" (ibid.). Participants' use of a loving family as a metaphor to describe support groups thus shows that the discourse of family can work through practitioners' understanding of support to promote particular ideals of family, which can marginalize and pathologize interactions within families that are not recognized as loving and nurturing by Eurocentric, middle-class social norms.

"People don't have to participate at all": Permission for varying degrees of connection. While participants emphasized facilitating the sharing of experiences as an important part of support, they also described approaches to support that were open to varying degrees of participation by the group members.

> N: Making sure that everyone gets time to participate, but also that nobody has to, people don't have to participate at all […] in fact have been given permission if they don't want to partake in the temperature check [a check-in exercise] they can.
>
> O: You have the right to be silent. And I think that's a really important rule, because I've also had the opportunity to check in with the people that only come once […] and the big part is they don't want to say anything yet, but they feel badly not participating, so they wonder if it's the right place for them. And I say if you can come here and sit and take a deep breath, just keep doing that.
>
> A: If they don't want to say anything they don't have to, I never make anybody participate. Um, because I feel like, I'll never forget I had this one woman that came for like three years straight she never said anything. But she, her listening was getting enough out of it.

D. described using alternative practices such as music-making as a way of facilitating a nonjudgmental environment that was open to various ways and levels of participation.

> D: When we do like one-word check-in or check-out, rhythm for check-in or whatever they

> can say something if they want or not […] hopefully there's a sense that there's no judgment. /Int: How do you facilitate a sense of nonjudgment in the group?/ Partly by like overarching statement like, ah, you know there's no mistake in drumming, only variations.

Furthermore, participants described informing group members that they did not have to come to group and they were welcome to return to group after absences, which paradoxically helped to maintain group attendance.

> N: Sometimes people would come in and they would […] apologize for, 'oh I'm really sorry I missed a few sessions.' And I would always remind the group I say […] if you're off and you're doing other things in your life and going out and socially interacting or engaging in some activities or going to the art gallery or doing life, please don't apologize for not coming, because that's the goal. It's that you incorporate more things in your life. That's part of recovery […] Maybe that's why people continue to come to the groups for so long because they felt that permission, it was never a, 'oh good when I get through these 12 weeks I don't have to come back.'

R. incorporated this idea in her artwork.

> R: For life gets in the way, and they might stop coming to the groups, but many keep coming. Or for a long time they don't show up and later on they show up again to groups […] And they said 'well, you know I wasn't ready.' That's why the word 'ready' is there.

Participants' comments thus challenge support group literature that attribute positive outcomes to active participation through sharing emotions and experiences (Wanlass, Moreno & Thomas, 2005; Staples & Schwartz, 1990). This creates an opening for clients' to define for themselves what the group means to them, how they want to participate, and how it might benefit them. Paradoxically, the words "permission" and "rule" were used to describe how facilitators encourage clients to participate in their own ways. In this sense, clients can remain silent or to be absent from group *because* those in positions of authority have interpreted that their listening would be "getting enough" out of the group and their "doing life" outside of group would be beneficial. The concern here is not about whether it is actually beneficial for the clients to be able to remain silent or be absent from groups; rather, it is to point out that clients' choices of actions are constructed as conditional upon the permissions and rules that the practitioners have defined. As Rose (1999) explains, the domination of psychological knowledge defines “[relations] of hierarchy, from age to educational qualifications and accreditation, locat[ing] individuals in chains of allegiance and dependency, empowering some to direct others and obliging others to comply” (p. 8).

“Have awareness of the people in the group”: Facilitating connections with rules and boundaries. Participants further described practices that define appropriate methods of interaction amongst group members, again involving the establishment of rules and boundaries for group members to monitor their own actions and the time they take up in group, with the goal of facilitating supportive relationships or at least courteous interactions amongst group members.

> R: Making sure that rules are expected. Um, that one person can speak at a time. Ah, in my group people have to raise their hands if they want to ask a question to another participant.
>
> N: There will be times when it’s really important for you to have the group’s attention, but have awareness of the people in the group who are, may have trouble jumping in […] So leave space for them.
>
> M: In terms of warmth, I try and set some guidelines at the beginning of the first group in terms of, um, you know being conscious to not any one of us to monopolize the conversation, how we will hear ah others, in terms of sitting back and letting people finish […] how we want to give some thoughts to how we might respond if we’re choosing to respond to any comment made by an individual.

A. described facilitating ways for group members to also define appropriate ways of interaction.

> A: What I find is after knowing that people in the group, people will ask permission, say, ‘I’m not sure if I can talk about this,’ and then I’ll be able to say like, ‘know people well enough in the group that we’ll be able to handle that, right now.’

Participants’ comments seemed to echo literature that problematizes clients who “dominated group sessions” (Wanlass et al., p. 56) in defining rules that can prevent group members from taking too much time to share or sharing experiences that may be too intense for other group members. R.’s description of asking clients to raise their hands clearly reflects a traditional classroom management strategy, a way for educators to instill the habit of self-regulation and self-monitoring in individuals who are usually younger and are deemed as lacking the skills to determine the appropriateness of their behaviours. Thus, the use of rules may also reflect the belief within psychological discourse that people living with ‘eating disorders’ have a lack of social and interpersonal skills (Choat, 2010). However, A.’s comment seems to challenge this belief by describing a practice of inviting clients’ knowledge in determining what would be helpful for the group to talk about. Foucault’s concept of governmentality comes to mind when considering the participants’ discussion of using rules to encourage clients’ self-regulation. Rose (1999) explains that governmentality is what allows the exercise of power through “institutions, procedures, analyses and reflections” (Foucault, 1979, p. 20, cited in Rose, 1999, p. 5). He refers to professional groups associated with psychological sciences as “expertise of subjectivity” (p. 2), which has “become fundamental to our contemporary ways of being governed and of governing ourselves […] by way of the persuasion inherent in its truths, the anxieties stimulated by its norms, and the attraction exercised by the images of life and self it offers to us” (p. 10). Practitioners thus offer and enforce rules to fulfill their roles as effective group facilitators, and the clients take up the rules to work toward a socially acceptable, respectable, and ‘normal’ kind of self, in accordance with the norms and values of a liberal society.

Assertiveness was also described as a way to support appropriate and effective interpersonal behaviours.

> O: You are allowed to be judgmental, because we’re lying if we’re saying we’re not. But I hope you would have the courage to work through it in the group.
>
> R: I tell them to be assertive. If they don’t want to hear any support or feedback or anything, they can say, ‘well, I just want to say this.’

The need for assertiveness seemed to be justified by participants’ understanding of people with eating problems as particularly caring and motivated to meet others’ needs but somehow less able to address their own needs.

> N: I think one of the most important things about what people get out of the group is that they can talk. And they can learn, you know safe environment to get feedback from other people […] to express criticism […] they can give feedback […] and they can then take

> those skills, the relationship skills, with them to other relationships […] And for people to express their needs. Particularly with eating disorders where there's such a connection of not being able to express one's needs, and having tremendous need, and often being so good at meeting the needs of other people. But not very good at um, having their own needs met.
>
> A: I think that it helps them to help each other, right? As you have probably learned through all of your work these are the people with some of the biggest hearts, right? They're really good at supporting each other, so challenging them to take their own advice […] like having group members kind of call them out on staff and, I think that's amazing.
>
> O: I try and help the girls to have a safe place to take a chance and say, 'that's offensive.' And I would say it's not what happened, it's what happens next. So you can go home and be pissed off at this group today, it's how we deal with it next, because you're going to be triggered everywhere.

Interestingly, while emphasizing rules and guidelines for clients to be aware of other group members' needs, participants also describe clients' desire to meet others' needs as 'features' of 'eating disorders,' consistent with clinical literature that essentialize difficulties in communicating needs and prioritizing others' needs as individual psychological features of 'anorexia' or 'bulimia' (Choat, 2010). Thus, it may be argued that women with eating problems are discursively constructed as too irrational and emotionally unstable to be aware of others' needs, hence the necessity of rules, and at the same time they are also perceived as hyper-aware of others' needs and unable to meet their own needs. The practices of encouraging or teaching assertiveness is prevalent in literature on support groups for women living with eating problems (Choat, 2010; McVey et al., 2003, McVey et al., 2004; Wanlass et al., 2005). As discussed in the literature review, the privileging of assertiveness, which is socially associated with masculinity, reinforces the gendered hierarchical binaries that idealize the masculine and positions women as that which men are not (Malson et al., 2007). Asking women to overcome their difficulties through being more assertive does not address the gendered social norms that devalue women's voices. It also perpetuates the contradicting standards of normative femininity that produce eating and body image problems in the first place. Moreover, it reinscribes a rather narrow, masculine definition of effective communication and ways to meet one’s needs, which are constructed by the participants and clinical literature as confronting disagreements and challenging others directly (Choat, 2010; McVey et al., 2003; McVey et al., 2004). These actions may not be possible and may even lead to backlash and serious consequences for women’s economic, physical, and emotional well-being within a kind of social order that subordinates women. However, women may find other ways to exercise power that may not involve direct confrontation, or actions of resistance that may not be socially recognized as ‘assertiveness.’ Insisting on teaching a fixed set of techniques of assertiveness may therefore render invisible the everyday knowledge and skills that women mobilize to challenge inequality and domination (Healy, 2000).

“Not everyone becomes friends”: Approaches to disconnections from and within groups. Disconnections within groups can be understood as conflicts between group members, group members having difficulties connecting with each other, or group members leaving the group. When asked to share about a time when their approach to support did not seem to work for certain group members, participants mostly spoke about group members leaving and disconnecting from the group. When asked why they thought group members left, participants spoke about group members individual problems but also questioned the role of their practices played in the clients’ departure.

> M: On why they leave? Ah, they’re not ready to work on the problem. They don’t feel comfortable in the group. That’s probably top two I would imagine […] They might have social anxiety, they might not feel included, they might feel judged, I mean the list is endless […] It’s probably not that fair, it’s part of what they’re struggling with […] and the other part being what could have been done to help them feel better within that circumstance.
>
> D: Sometimes people come once or so and then they don’t come back and then you know I wonder whether it [drumming instruction] was too fast or was it, tried to make it welcoming for everyone, but I really don’t know why they don’t come back.

Yet the reasons for disconnections were mostly attributed to group members’ individual problems.

Lack of readiness for change and substance use were cited as reasons for the group ‘not working’ for clients.

> R: It doesn’t work for the ones that are in contemplate, still contemplating or even in complete denial […] If it doesn’t work there is no way I can know. Because they might show once and then they don’t show up, but we don’t have information why, if something else happened, and if they’re not ready well it’s not that it didn’t work it’s that they’re not ready, and they might come back later on.
>
> A: That’s when it’s important to know what kind of support group you’re getting into, right? Making sure that the individuals that are in the support group are, if it’s possible kind of at that same place as they are, rather than you know recovery mode and going into a group where it’s a bunch of people that are very ambivalent about change, that would be very damaging.
>
> A: I’ve had different instances where people had been struggling with substance abuse as well, and sort of show up to a group and they’ve been intoxicated, and they’ve been um very inappropriate. And that’s cased the group to be a really challenging group.

For others, interpersonal issues had created disconnections in the groups.

> O: Sometimes people that have seen me individually, if they come into the group as another way to have contact with me in a week that’s free, they have a hard time sharing me. And so for certain people, they don’t find that the group works, because it just becomes another way to feel unimportant […] Or maybe they have more personality issues. But not everybody likes it.
>
> L: At the end of the day conflict comes up in a support group. Not all personalities mesh well, not everyone becomes friends […] I think as a facilitator if you continue to give space to everybody and that one person doesn’t want that other person to continue to talk, that’s not going to go well. And that client may then think that you’re not the facilitator for me, or […] I don’t like the approach that you’re taking in this group, because they have their own stuff going on, that overpowers what’s happening in the group.

Other mental health issues and eating problems that seemed substantially different from ‘eating disorders’ were also described as challenges, and rules and boundaries were established to prevent problems that may undermine the relationships of support among group members.

> O: Because this is a very multicultural university, and everyone has a different idea of what disordered eating is, and I’ve seen some very, very sad things show up in my group that yes they’re not eating but it’s more serious mental health, it’s more refugee, like it really shook my group.
>
> N: I actually have exclusion criteria […] it would be that someone has too severe mental illness to be in the group […] someone does need to be able to sit in a room, and to, even if

> they don't talk, to be able to be somewhat present. Because it really is disruptive and can be hurtful if someone is getting up and leaving […] people coming and going in groups […] there would be all sorts of boundaries that are crossed in terms of being respectful. And so there have certainly been people that I had to ask to leave.

Attributing challenges in the therapeutic process to clients, especially their perceived lack of readiness for change, is common in clinical literatures on eating and body image issues (APA, 2006; McVey et al., 2005; Wilson et al., 2007). Particularly, in the participants' discussions those who are seen as being in "denial" and not going in the same direction of 'recovery' as other group members, those who are dealing with substance use issues, those who experience eating difficulties that are not commonly perceived as 'eating disorders,' and those with "personality issues" are seen as getting in the way of relationship-building in the group. The open group format and new membership were also described as a source of challenge in facilitating safety and supportive connections amongst group members. O. again employed the concept of family as a way to facilitate relationship-building in an open group.

> O: So one of the problems with an open group is creating safety, because every week could have new people. And that's hard, it's hard on the facilitator it's hard on the group members […] what if we have four times a year where we take in new people, and in it it's like a family where you celebrate the work you've done so far, where it's like a birth when someone new is coming in and we have veterans people feeling like a little bit of a mentor […] because I know that if my group can complain about one thing, they don't like the new membership all the time.

In another study, clients of support groups do report having difficulties with new members in terms of building trust and connections with others (Choat, 2010). Following Ahmed's (2004) theorization of how emotions shape and are shaped by social processes, it may be argued that clients who are dealing with unfamiliar problems or are themselves unfamiliar to the group are constructed as the origin of tension and anxiety. Clients' personal issues "shook" and "overpowers" the group, thus threatening the emotional safety of the collective that is bound together by specific definitions of 'eating disorders.' They are positioned as being different from the ideal group member in terms of their ‘recovery’ goals and the ‘nature’ of their struggles. The acceptance of the unfamiliar new members is built on the discourse of family, which reinforces the binding effects of the ideas of shared experiences and similarity between group members. Those who are viewed as different are therefore constructed as “not us” (p. 1), and “who in not being us, endanger what is ours” (ibid.). In the context of what participants have described, ‘what is ours’ can perhaps be defined as the support services provided through the groups, the space to speak and be heard, access to the facilitator’s expertise, and the supportive relationships built on the shared experiences of ‘eating disorders.’ Protecting ‘what is ours’ necessitates the enforcement of “exclusion criteria.” Indeed, Gremillion (2003) explains that “the racialized and classed norms that define eating disorders in dominant popular and clinical narratives […] may preclude the recognition of significant eating problems that are ‘nonstandard’ and perhaps more widespread” (p. 158), and construct nonstandard clients as a drain to the resources that are geared towards those who ‘legitimately’ need help for ‘eating disorders.’ She continues to suggest that “‘nonstandard’ meanings may be assigned to the eating difficulties of economically underprivileged or nonwhite people when apparently identical problems would otherwise be labeled as standard (for white and middle-class people); doctors and mental health professionals sometimes participate in this process because of preconceived ideas about ‘typical’ patients” (p. ibid.). Research has established a strong link between substance use and eating and body image issues (Canadian Centre on Substance Abuse, 2013), and ambivalence about change is a common experience of women struggling with eating difficulties and weight management practices because of how culturally normative these practices are in the western society. Psychological and psychiatric discourses that define who is legitimately deserving of support and exclude others based on discursive constructions of emotional safety and shared experiences can therefore create barriers for a significant number of people to access support for eating and body image difficulties.

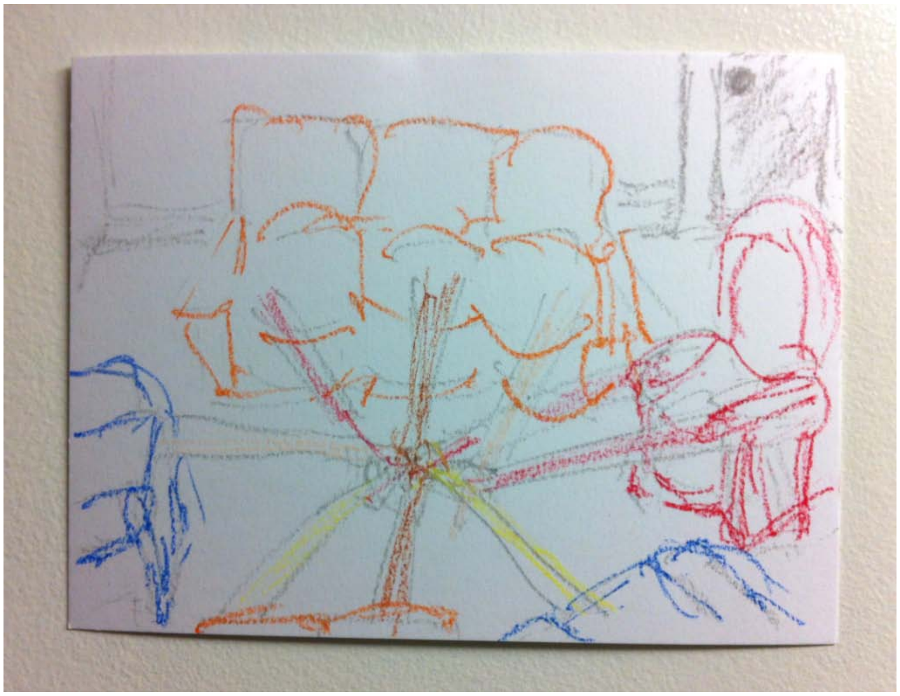

Figure 4. N.'s artwork.

"Facilitating support, um, there's the closed door. And these are safety issues. Just making sure people feel that they can be safe in saying whatever they want. Um, and that is confidential. So that's what the closed door represented […] people have always known that I move the furniture. And I've been known for that for years and years and years. And that is because I believe that how we sit and how we arrange chairs could absolutely influence how safe the group feels […] it's basically to create a safe and very, and an intimate circle. Um, with no barriers in between […] And so these are all hands, arms, and um they are the different colours, the Caucasian flesh, the red flesh, the brown flesh, the, um, the yellow flesh. Um, just representing the diversity. Because I believe that, or the experience of my support groups is that you can have incredibly diverse people from any almost any age […] what I've always been amazed by is if I believe one can facilitate just about any group and bring out the connection in the group. It's, I'm always amazed, and ah I'm always struck by the fact that you can work with people all different ages all different socio-economic backgrounds, um, different body types, different skin colours, different religions. You can pretty well put together any people. I do the same around my dinner table here, different politics whatever. But it's how it's facilitated. And creating an environment that's respectful where everyone can be heard." – N.

Support as Solutions to Challenges of Difference

When asked about how they take into account issues of differences and diversity when facilitating support groups, the participants suggested that, despite the differences in the particulars of clients' cultures and personal histories, connections and mutual support can still be facilitated through identifying similar or even "the same" experiences of eating and body image issues amongst group members. At the same time, they also described support as openly addressing issues of difference and avoiding making assumptions about clients' experiences.

"Bonding over this terrible thing": Facilitating support by seeking similarities across differences. Participants described working with individuals coming from diverse backgrounds but reported that issues of difference were not a concern.

> A: Having people of all different ages and ethnicity and income levels and, all just coming together and really bonding over this terrible thing, I think can be quite empowering.

> L: To be honest I don't hear about it too much in groups. It doesn't seem as many issues come up about that, which I think is great. At the end of the day you're there in group to get the support for the area that you're struggling with, um, not because you're an individual of certain ethnic background or religious background.

N. described her artwork in this way.

> N: These are all hands, arms, and um they're the different colours […] just representing diversity […] I believe one can facilitate just about any group and bring out the connection in the group […] you can work with people all different ages, all different socio-economic backgrounds, um, different body types, different skin colours, different religions, you can pretty well put together any people.

When asked about differences in the group participants often turned to issues of gender differences. They explained their belief and observations that mutual support between group members was possible through sharing similar experiences, but also acknowledged the challenges for men to participate in groups that were mainly attended by women.

> L: We have somebody that's transgendered, and we have someone who's gay […] we've had conversations saying, do you feel this group needs to be split up in the sense of having a space where gay men come, a space where straight men come. At the end of the day they

> said, ‘no, we’re all men, we have the same experiences, we’re just here to get help.’ […] To be honest it surprised me a bit […] we have seen challenges in groups where men and women are in the same group […] we have to recognize that there’s going to be tension and that there’s going to be very different points of view coming into the room.
>
> A: I feel like it’s a huge barrier for men […] I’ve worked with some transgender or individuals that are kind of in a place of where they are questioning their gender and that, um, they find groups very difficult, because there are some things that they cannot relate to […] I did have a couple of instances and I felt terrible, where the men did show up at the support group […] he walked into the group, looked in the room and saw that it was all women and he just left […] and that’s, you know, so tough, right? Because it’s already such an isolating illness […] if he were to sit down he would very quickly realize that you know his thoughts are the same and everything. But I think initially, that’s very hard.

Participants therefore emphasized practices that encouraged group members to recognize their similar experiences despite their differences not only in regards to race and gender but also diagnoses and experiences of eating problems, such as raising relatable topics for discussion, facilitating an understanding of common underlying issues, and ensuring similarities in group members’ backgrounds through the intake process.

> A: I think it’s almost the same sort of practices as is, you know, when you look into your support group and you realize that there are seven different eating disorders in the room […] so you have to find relatable, relatable topics.
>
> N: You can bring any people with any type of eating disorder together […] whether you restrict, or binge or binge and purge […] the bottom line is that um, it’s very much about need and it’s about numbing, and it’s about coping […] I mean I believe each person has an eating disorder for their own good reason. But […] there are some very common themes that run throughout, which is why groups work so well.
>
> O: I believe in matching people in your group. I try to, like if I’m going to take someone with major anorexia I don’t take them unless I can match them with someone else because I don’t want anyone to feel alone in their symptoms […] ideally I want to match ethnicity too.

Similar to earlier analyses regarding the assumed shared experiences of eating and body image issues, in the participants’ comments there seems to be a separation between people’s experiences of eating problems and their social positioning, reflecting a humanist discourse which sees the individual as separate from the social (Moulding & Hepworth, 2001). In contrast, critical feminist discourse sees eating and body image issues as constituted through and therefore inseparable from local, historical, and social contexts and discursive practices (Nasser & Malson, 2009). While each person's experience of eating and body image issues is highly localized and specific, there is no doubt that similarities exist among individuals' experiences. Group members may even define their experiences as similar or even the same as others' due to the hegemonic language that is circulated in both clinical and popular narratives about 'eating disorders' (Gremillion, 2003). As Scott (1992) writes, "experience is a linguistic event (it doesn't happen outside established meanings)" (p. 34). The similarity or sameness in people's experiences is constructed as a solution to mitigate the tension that can arise among people coming from different backgrounds. This construction may then be built on the assumption that differences can disrupt connections among group members, implying that difference as something that needs to be overcome. This may not only subjugate alternative knowledges of eating problems, it can also precludes an examination of how various social and systemic inequalities give rise to health-compromising eating practices, self-loathing, and body dissatisfactions.

"One has to be curious, and not make assumptions": Facilitating support by acknowledging differences. In ways that seem to contradict earlier discussions about approaching difference through facilitating the recognition of similarities, participants spoke about facilitating support by bringing up and exploring differences in the group, thereby challenging assumptions especially around food, body image, and gender.

> M: Again part of the whole cultural discussion in terms of people's personal experience within their own culture and messages around food and their body […] for example what does it mean to be bigger bodied in a West Indian country or a third world country compared to North American country, those kinds of things.
>
> O: Right now I have one aerospace engineer in my group, and everyone is in a touchy-feely faculty, and she's being a little bit ostracized […] no one would expect someone from aerospace engineering to have an eating disorder. So it's not just ethnicity, it's, it's all the assumptions and so I always say to the group, love is how you work through how you're different, it's easy to be the same. And when I notice that people start not wanting to come, it's usually because they're either angry, or they're feeling really different, and so that's

> what you need to bring, right? So it's encouraging that, it's okay, let's talk about what's going on […] we'll bring it up, and we love to learn.
>
> L: We know that, or we think we know, women have higher rates of having eating disorders, because they will say so […] We don't go out on the street and ask every man that's out there, men aren't coming forth in saying that they have eating disorders issues or body image issues, so at the end of the day our numbers aren't accurate, so I don't think it's fair to jump to the statistics we have about women. Um, from what we're hearing from the men in support groups here is that, you know they've gone to their doctors, doctors have told them to be a man and get over it […] I don't think we would say that to a woman who would come to the doctor and she was saying "you know I'm not eating", or "I purge 15 to 20 times a day" […] It'd be a different conversation. Um, so the stereotypes and that sort of 1950s way of thinking that a man is tough and he is built and goes to the gym and eats meat and potatoes, and a woman worries about her weight and tries to please men, is so very prevalent in society.

Participants also described anti-discriminatory viewpoints and practices as part of their approaches to support. L. described her artwork as follows.

> L: I did like a rainbow selection because I think safety needs to be a part of support, and that's recognizing anybody's background, sexual background, ethnic, religion, absolutely anything that should never be a factor that would change the support you receive.

Likewise, in explaining how nonjudgment may be facilitated, D. stated:

> D: Acceptance I guess, because um you know we don't tolerate any homophobic or racist or whatever comments.

A. and N. described conveying inclusivity through the construction of physical space.

> N: If people walk in and they see tiny chairs, where they can't fit in any of the chairs. You know at some levels we have to be realistic if we are you know using space of a church or, you deal with what you have, but if you're going to offer it to people, you have to make sure you have some furniture that doesn't, or couches, or something that conveys that yeah, that person could actually sit on that.
>
> A: In terms of safety, try to make sure that my office here is not full of pink and purple flowers (laughs), you know make it pretty neutral […] it's gender neutral, right?

Participants' description of their practices of inclusiveness can certainly challenge discriminations against fatness and the stereotypes that assume people with eating problems are underweight and female. Moreover, O.'s and L.'s earlier comments challenge discourse of gender that feminizes eating and body image issues by constructing these issues as relevant to both women and men, or both women in “touchy-feely” or feminized university faculties as well as women studying subjects that are typically masculinised, such as aerospace engineering. However, their comments seem to imply that anyone can have an ‘eating disorder,’ which does not challenge the assumption that eating problems are *individual* psychopathologies with the same psychological ‘nature’ within individuals, despite their different social positioning in various relations of power. Critical feminist analysts argue that the “prevailing conception of gender is understood as an ideological structure that divides people into two classes, men and women, based on a hierarchical relation of domination and subordination, respectively” (Lazar, 2005, p. 7). Certainly, L.’s comment challenges the “social perceptions and the cultural representation of women as the group who are most affected by the condition which results in males’ unwillingness to disclose details about their ‘eating rituals’” (Hepworth, 1999, p. 71). However, the use of “rates” and “statistics” of “eating disorders” to suggest that women may not be more affected by ‘eating disorders’ than men can obscure the gendered hierarchical binaries that positioning “‘women’ as the negatively signified binary ‘opposite’ of ‘men’” (Malson & Ryan, 2008, p. 115) and the gender inequalities that constitute and are articulated through women’s eating and body image difficulties (Malson, 2009), which are now paradoxically producing tremendous barriers for men to access support for eating problems. M.’s comment about exploring the different meanings of food and the body may create an opening to challenge explanations of the psychological discourse by considering eating problems not as individual psychopathologies “but as an attempt to embody and convey a ‘self’ (i.e. an embodied identity) via embodied practices” (Burns, 2009, p. 130), practices that are shaped by gendered and cultural values and norms. However, Nasser and Malson (2009) warn about conceptualizing ‘culture’ as “definable, contained, unitary and relatively stable” (p. 76) when examining the cultural meanings of eating and the body, such as the meanings of being “bigger bodied” in a “West Indian country or a third world country,” which can inadvertently produce homogenizing stereotypes of non-western cultures and gender norms.

N. described her approach to working with a particular client in her group who was dealing with a problem related to a different culture.

> N: A few years ago I had a woman referred to me and she was from, Southern Africa […] And she was referred to me by a therapist because she had basically body dysmorphia but it was just to do with her face. It was to do with the way she saw herself as extremely disfigured […] And then the more I researched her culture and background and thought about, in her culture, the only thing that shows, is her face […] So a lot of that body dissatisfaction, the self-esteem, the body hatred, all got brought to her face […] no matter how long I've worked in the field, or how much I've travelled, I think one has to be curious, and not make assumptions.

Ironically, 'body dysmorphic disorder' is a western construct, a psychiatric entity as defined by the DSM (APA, 2013). In N.'s narrative the client's experience of distress is constructed to fit within a predetermined construct of "body dysmorphia." The diagnostic definition as determined by a psychiatric discourse, rather than the client's narrative, is the starting point of explanation, which is further substantiated by N.'s research and interpretation of the client's culture. The cultural and localized meanings of the client's distress may therefore be overlooked and subsumed under the dominant discourses of psychiatry and psychology. N.'s comments therefore point to the importance of questioning the Euro-American foundation of counselling and therapeutic practices in our western society.

Figure 5. R.'s artwork.

"I think about support groups, like, a place where people maybe start transitioning. Slowly, getting ideas, and things that they can do in regards to their health. Um, I actually, that's why I'm show, I put this image of a girl that is, she got hurt it seems, she's crying. And then on the other side there is a lot of balloons and colourful, that's supposed to be a better place, right? And in the middle there is a boat with many people and that's supposed to be the group, right? So what I think is that groups are so important for people with eating disorders. Because they can relate, they can break isolation, um, they can gather strength. And also to share strategies […] the idea is that people with eating disorders are doing the best they can, when they arrive to the group. And at the same time, they can still do, uh, better, they can still improve […] In the direction of health. So, and accepting whatever reality they have, at the time. So both things. And I think that's the idea of this picture. I tried to do that. And it's a transition. Because I think every person that joins the group, even if they only do it for one meeting, they are changed. They know what a group and the things that they can hear, they might not feel it's a good experience for a few people, what I have noticed is that many keep coming. And then for life gets in the way, and they might stop coming to the groups, but many keep coming. Or for a long time they don't show up and later on they show up again to groups or to [agency]. I've heard, people who haven't been at [agency] for years and then suddenly they show up. And they said well, you know I wasn't ready. That's why the word 'ready' is there." – R.

Support as an Alternative and a Bridge to Treatment

When speaking about their views on community-based support groups and the groups' relationships to institution-based treatment, participants referred to community-based support as more beneficial to clients than formal treatment in some ways, especially in regards to the idea of safety, and described attempts to construct a support group setting that was as different from treatment settings as possible. However, in other ways they also seem to construct community-based support as lacking in comparison to treatment in terms of effecting concrete, positive changes in clients' eating practices and physical health. They therefore described comprehensive support as involving collaborations between community-based support and formal treatment.

"This group is not a treatment": differentiating between support and treatment. When asked about how they saw community-based support groups relate to treatment, participants clearly differentiated between the two. For example, after discussing at length about how DBT informed her approach to group facilitation and the specific DBT exercises that she used with the group members, R. explained:

> R: As I said it's not, it's more support what we do, we don't do DBT.
>
> R: What we stress is that the groups at [agency] are not, um, therapy groups. They are support groups. It's not a treatment.

She further explained her perception of how support groups differed from treatment in regards to her responsibilities as a facilitator.

> R: It's different because I have less responsibility, um, regarding the outcome or the result from the group, in regards to the participants' health […] This group is not a treatment, but that hopefully you, the participant will go in the direction of health. I mean what they need is a treatment.

M. and A. explained the difference between support groups and treatment in terms of their objectives and expectations in regards to changes in clients' eating practices.

> M: So I think of treatment groups is focused you know a little bit more on behaviours and

> symptoms that somebody is trying to alleviate, and or emotional processing that's involved with dealing with the underlying issues […] As to support groups that is not specifically looking at individual behaviour modification or improvement, or emotional processing in a formalized way […] So that's the difference. The treatment meaning we're working toward alleviation of the problem, and then the six to eight weeks support group you are definitely not going to alleviate the eating disorder. You might improve symptoms, but it's merely one piece of the long puzzle.
>
> A: This really shouldn't be a focus on making food goals or symptoms and, like, it's helping people get past the pre-contemplation stage and get into the stage where they really want to make some changes and, keep them in recovery stage.

Indeed, N. described structuring the group she facilitated in certain ways to deter group members from forgoing treatment.

> N: There can be a lot of overlap […] the groups that I talked about in Vancouver I ran too on two nights a month […] the intent being that I didn't want people to see it as a replacement for therapy […] some people you know, some people make a lot of changes through just attending support groups, but some people need more […] the majority of people need additional support than just a support group […] there are other elements of recovery that are really important […] people ask me what I'd say, you know talk about the medical and the nutritional.

When asked about her hopes for community-based support, R. replied by defining treatment as more urgently needed than community-based support, and drew on what she heard from group members and her knowledge about services from her home country in South America to explain the importance as well as inadequacy of treatment in Canada.

> R: That's the concern that is voiced again and again in the support groups, that there's no treatment, for binge eating disorder, that there's not spots for ah bulimia and anorexia at hospitals, that they have to travel to other provinces, they're in waiting lists for 6 months or more […] And then the treatments are short. They're not focusing on complete recovery here, that's a big difference. In my country many of the treatments are focused on complete, fully recovered. So the treatments are long term. Here are short terms. They just address the more urgent symptoms.

These participants' constructions of the relationships between community support and formal treatment reflect how power operates through discourses of medicine, psychology, and psychiatry "as a productive network which runs through the whole social body" (Foucault, 1980, p. 119, cited in Guilfoyle, 2001, p. 154). Participants use psychological terms such as "pre-contemplation stage," which comes from the transtheoretical model of behavioural change (Zimmerman, Olsen & Bosworth, 2000), and "DBT" to describe their understanding of clients and their approaches to practices. Yet they also clearly emphasize that what they are providing to clients are "not DBT," "not treatment," and the groups are not "therapy groups". Thus, their comments reflect that while their practices involve an appropriation of psychological and medical discourses outside of medical settings, and the ability to effect concrete, positive changes in clients' lives are understood as resting in the hands of those with higher degrees of authority within the medical institution (Guilfoyle, 2001). As earlier analyses demonstrate, group facilitators may be positioned or position themselves in expert positions within psychological discourse in relations to the clients; however, within networks of power relations community-based practitioners may be positioned as having less expertise than clinical practitioners such as doctors and psychiatrists, or even as "non-experts" (Guilfoyle, 2001, p. 158), depending on their training backgrounds. The participants' appropriation of psychological knowledge and the simultaneous delimitation of their use of this knowledge reveal the effects of discourses, which "operate not only by delimiting the number of people who have access to certain 'Truths' (as in professional discourses) but also by establishing a strict regime of what counts as Truth" (Healy, 2000, p. 41). "[Non]-experts," writes Guilfoyle (2001), "by definition, should not be able to grasp the object's apparent psychological complexity" (p. 158). He further explains that when a phenomenon is discursively constructed as a psychological or psychiatric entity, like 'bulimia,' "its complexity is highlighted, raised for attention, by its very definition as a psychological issue. A proper, comprehensive, or working understanding of bulimia is therefore excluded from the lay public, and the possibility of effective local, non-expert intervention is undermined" (ibid.). Indeed, R.'s definition of her role in a community-based setting as having "less responsibility" for the outcome or results from the group, as well as M.'s comment that treatment is intended for the "alleviation of the problem" while support group is not, seems to construct community-based practices as somehow less ‘potent’ than practices conducted in clinical settings, thus potentially precluding a recognition and reflection on how significantly facilitators’ practices can impact on clients’ well-being in both positive and negative ways. As our “contemporary era is characterized by the widespread phenomenon of biomedicalization, wherein medicine becomes a dominant institution of social control, an arbiter of truth” (LeBesco, 2009, p. 150), it is not surprising to see the necessity of institutional-based treatment emphasized by both practitioners and clients. Certainly, medical and psychiatric treatment can be greatly beneficial for people who engage in eating practices that can seriously compromise one’s health, such as binge eating and self-starvation, and are experiencing tremendous levels of distress. However, the concern with dominant discourses is that the truth status of certain knowledge, such as prescribed body weight as a measure of physical health and eating behaviours as observable evidence of psychological well-being, conceals the operation of power that upholds the authority of certain knowledge while subjugating other ways of knowing that can be just as important or perhaps more important in some contexts. For example, feminist practitioners have long been suggesting that practices of self-nourishment can be difficult to sustain without changes to the social contexts and norms that give shape to eating and body image problems (Black, 2003; Burns et al., 2009; Malson et al., 2011; Piran, 2010). Yet medical treatment continues to be positioned as more crucial while the constitutive effects of gender and cultural discourses are ignored, as evident in the pretension of gender and racial neutrality in contemporary treatment models (Gremillion, 2003; Moulding, 2006).

On the other hand, community-based support was also described by other participants as different from formal treatment because it has greater capacity than treatment programs to meet clients’ diverse needs.

O: I’ve always provided support to people that can’t fit into the usual programs. They’ve

> tried everything. And I do it because no one should feel like, it's kind of like you know when you're feeling in your family no one gets me, no one can handle me, feels just as bad for the systems to say that too.
>
> L: So at the end of the day […] you can come here and have a men's group. You don't have to go to your doctor and continually be shamed or not welcomed into a medical program. So I think that's another difference looking at that in the community.
>
> N: We ran groups for um, compulsive eating and binge eating, and did that because nobody else was. Treatment was only you know for anorexia and bulimia.

Participants also described support groups as alternative options for people who did not wish to access traditional treatment. When asked whether she would want the drumming group that she facilitated to involve more discussions about eating and body image issues, D. replied:

> D: No […] people come for something different, a break from it, to relax, decrease their stress.

Likewise, A. explained:

> A: I find for the most part when people are interested in a support group, they got a little bit of treatment burnout, and they're not looking for that sort of thing.

Indeed, participants spoke about constructing an environment of support that was as different from treatment settings as possible, which they also linked to the idea of facilitating emotional safety.

> A: I try to make it look as different as a clinical setting as I can. So very comfortable chairs, warm colours, lots of blankets, pillows […] also the positioning of things. So I had an experience, when I first started doing a support group at [agency], there was a really old TV in the corner, and I didn't even think anything of it, but after a couple of sessions, some of the women said 'can you cover that TV up I can see my reflection in it.' So being really aware of kind of what's around that might be causing that […] they love that I always have blankets because they make them feel safe, they can wrap themselves up in a blanket and they don't have to worry about how their bodies feel when they're sitting down, or that sort of thing.
>
> L: You're not walking into, you know, shined white floors in a hospital, you're not walking in seeing medical equipment, you're not seeing people in suits or dressed up or in nursing scrubs […] people go into treatment because they need to be nourished and they need to have intensive medical care. I wouldn't, as much as people may gain skills and recover, I don't think that on average people think that that was a really pleasant experience, right (laughs)? Or people sitting down and watching you eat a meal. That's not fun […] People are coming because they want to come. The doctor's not telling you to come. You don't need a referral form […] We don't have a wait list […] the second you call us, or come through the door within 72 hours you're in a group […] we are free, so

> whether or not you make it into treatment after a waiting list and maybe that's covered by healthcare, sometimes you don't.

O. and D. explained that they had more freedom in how they facilitate the groups as they saw fit. When asked about how she saw the relationship between support groups and treatment, they replied:

> O: It's freer. I used to work at [hospital] eating disorder program. Um, lots of rules. Just formula, psycho-ed.
>
> D: The setting is less intimidating […] there's less formality […] there's good staff support for people who are running groups. Um, there's freedom to experiment, and to try out new ideas.

Participants' constructions of support thus suggest processes of negotiation within dominant discourses. On the one hand they seem to appropriate knowledge that are sanctioned by the psychological discourse to legitimize their practices. At the same time, being positioned within the networks of power relations as having less expertise seems to have created space for practices that shift away or resist the authoritarian approach and constant surveillance of the body and eating behaviours that characterize medical and psychiatric treatments for eating and body image problems. Their comments thus expose the limitations of psychological and medical discourses and their truth claims about what people need to resolve their problems. As such, while practitioners working community-based support and those working in formal treatment can be understood as positioned within a network of power relations where the latter may exercise power and authority over the former, their positions are not fixed (Healy, 2000).

"The groups as a stepping stone": Collaborations with treatment. At the same time, the truth claims of medical and psychological discourses are once again reinforced when participants construct support groups as a way to reduce feelings of ambivalence toward accessing psychiatric and medical treatment.

> A: I can think of so many instances where the group helped someone into treatment, it

> helped to get them to see that, ‘you know this is the treatment that I went to and it was really helpful for this reason.’ And when they hear that from someone, it’s so safe, right? It’s not a clinician telling them that.

R. depicted in her artwork the role of support groups in facilitating transition towards formal treatment.

> R: I think support groups, like, a place where people maybe start transitioning. Slowly, getting ideas, and things that they can do in regards to their health […] I put this image of a girl that is, she got hurt it seems, she’s crying. And then on the other side there is a lot of balloons and colourful, that’s supposed to be a better place, right? And in the middle there is a boat with many people and that’s supposed to be the group.

Furthermore, A. and M. spoke about the usefulness of support groups before as well as after treatment.

> A: I think that groups are great for, um, preparing for treatment in a way […] What I hear, is that the biggest barrier to treatment is that people don’t want to do group-based work. People are very apprehensive, for very good reason, um, this is something I’ve never talked about before, why would I want to talk about it with a bunch of people I don’t know […] this gives people an opportunity to get used to it. So I always suggest, why don’t you go over to [agency] and see how you feel, you need to get used to that kind of thing […] I think that, through the transition out of hospital and treatment setting it can be really helpful, um to look at more long term support kind of thing.
>
> M: I personally see the groups as a stepping stone […] maybe a starter to getting more serious about treatment […] or sort of an after treatment opportunity to continue to feel supported. In terms of hospital treatment it definitely is more treatment focused as opposed to support oriented, but also in my opinion not the be all and end all.

Treatment, while defined as “not the be all and end all” by M., is nevertheless positioned as one of the goals of attending support groups. The group format is often used in treatment for eating and body image issues because of its cost-effectiveness (Wanlass et al., 2005). Thus, a neoliberal discourse may be at play in producing the taken-for-granted belief that group work is effective in supporting people with eating difficulties. A.’s comment that clients “need to get used to” group work in order to be ready for treatment may reflect this unquestioned belief about group work, or it may also suggest her awareness of a lack of available options for people seeking help for their eating problems. Either way, it places the onus for change on the clients so that they can fit themselves into the requirements of the system rather than acknowledging that the system is inadequate in meeting people's needs. This reflects a neoliberal discourse in positioning individuals as solely responsible for their well-being (Gibson et al., 2007).

Collaboration with treatment was emphasized as an important aspect of support, whether working within support groups or the community-support sector as a whole.

> A: I guess part of it too is having some consistency with the treatment world, right? So if people are coming for support group because they're frustrated with 'oh my doctor is making me do this' […] I'm very committed in keeping my feelings in line with the treatment world, so never going against them and saying, 'that's why you're here and we're going to fix you with this.' I guess respecting kind of the evidence based practices as well.
>
> L: Whether or not it's referrals, knowing what resources are out there, offering training, how can we be better at supporting people who are struggling, that's how it's going to happen. We can't do it on our own, we can't do it with the perspective that we're going to be the best at eating disorders […] we have monthly meetings in going down to [hospital], what are you guys doing down here, what's NEDIC [National Eating Disorder Information Centre] doing, what are we doing, is there overlap […] in the last week after talking to people at NEDIC, so many people are calling in with binge eating concerns and behaviours. So now for the spring we've added another binge eating group. So I think without having that communication, we're not serving people the best that we can, and we're not finding the gaps, or we're not finding what's working really, really well and pushing that forward. So we need to co-exist, we need to support one another.

Continuing on to describe her hopes for community-based support, R. shared her vision for an integrated model of support.

> R: if I were going to ask what I would like, I would like integrated. Treatment and community support. That's the model I, I facilitated groups at a treatment centre back in my country […] So people would have ah, before the treatment they have the support, during the treatment, and the treatments are long, but after they also have the support […] the relapses were minimal, 'cause the treatments are longer and there was support all the time […] Not just here it's kind of like a puzzle. The support here somewhere in one town, in Ontario in another town, maybe they get the treatment which is only focusing on restoring weight, and then they have to get another individual therapist to address the cognitive and emotional part, so scattered. And that's so difficult for somebody that is struggling.

Echoing R.'s view, participants commented on the inadequacy of current resources for eating and body image issues and recommended an expansion of community-based support to increase options for people living in different circumstances and communities. They also spoke of the underutilization of current resources and the need for increased outreach efforts.

> M: I think there's more that can be done to reach people, to let them know what's available, and to encourage them ah to have community support […] I don't think that it's been well used, in particular maybe in York region or outside of Toronto.
>
> N: It's a huge city, but ah there's not more. And I mean online support is, I think that's another avenue […] there is an online support group in the city, doesn't get used much.
>
> R: More support groups, and more outreach […] for instance that people that don't speak English very well, you know, like other communities, ah immigrants, that they will not visit sometimes a place that they cannot find somebody that speaks their language.

In suggesting expansion for community-based support, N. recognized that conflicts and negative experiences routinely happened in support groups, leading to clients disconnecting from the groups they had been attending. She therefore stressed the importance of having additional options for support in a community.

> N: There needs to be more than [agency], 'cause there are many, many people who don't go to [agency] for a variety of reasons. Um, stigma […] You know there are many people who won't, wouldn't want to go there […] for confidentiality, for their perception of groups […] it's about finding facilitators that they feel safe with.

Participants also recommended partnerships with hospitals as well as other community resources in order to expand community-based support.

> O: Collaboration is important. Like MEDACT [Modified Eating Disorder Assertive Community Treatment] […] the TGH [Toronto General Hospital] community-based portion. Like I think there should be more, um, things like that […] what's the word I'm looking for, organic.
>
> A: Maybe increasing the amount of them, right? Making them more accessible. I think that having them at universities and things like that are, um, one of the places that's a bit easier.
>
> L: I think that a big goal at the end of the day is money. Um, there is not enough support being offered. If you look at what you know available resources there are in [city] and realizing what we're doing and no one else is doing it […] It could be you know partnering with more community centres looking at who has space, who's interested in the field, ah can we do more fundraisers, can we be you know getting together and advocating and writing letters to the government […] if we want to truly look at the power and success of support groups, they need to be expanded within the city, within rural areas, across Canada. Is it something that we can you know kind of standardize, so that becomes part of

> your care rather than thinking, okay so you go to a hospital, you've got 3 months, you've got your doctor, you've got your dietitian, you got your nursing team, after 3 months we wash our hands and give you a "good luck", that doesn't seem the most supportive to me. So I'd like to start seeing more support-like groups fill those gaps.

Collaborative relationship with the institution of psychiatry is valued in the participants' constructions of support. Particularly, A. described "never going against" and "respecting" evidence-based practices. Witkin & Harrison (2001) write that any claim of evidence-based practice or "what works" (p. 294) "must fit the rules of the social situation in which it is used and be negotiated with those who have the power to legitimate the claim" (p. 295). Given that most areas of contemporary life are dominated by psycho-medical discourses (LeBesco, 2009; Guilfoyle, 2001), claims about what counts as evidence likely reproduce psychological knowledge while subjugating other forms of knowledge, such as clients' own understanding of their situations. While it is important to coordinate services and collaborate with other agencies, including hospitals, the participants' comments raise the question of where might clients find the space to question, inform, and challenge service providers' practices in both community-based and clinical settings. The inadequacy of both community-based support and treatment are constructed by participants around the *quantitative* aspects of services, such as the duration of treatment and the number of support groups or agencies within and outside of the city. They also recommend increased effort to encourage the use of existing services. However, what is not mentioned is an examination of the *qualitative* aspects of services, in terms of the practices that are used, the effects of these practices on clients, the knowledge that shapes these practices, and the ways that practices and practitioners are implicated in power relations with clients and within the broader mental health and social service systems. Simply developing more services based on similar models and practices without critical examination of these models and practices may produce limited benefits. In the following chapter, I will discuss some ways through which service providers may rethink practice, particularly in a way that involves creating space for clients to both question and contribute to the development of knowledge and practices of support in the area of eating and body image issues.

Chapter 5: Discussion and Conclusions

Implications for Practice and Future Research

This study aims to explore the meanings of support in practitioners' facilitation of support groups for individuals living with eating and body image issues. Specifically, it is concerned with the discourses and power relations that give shape to and are reinforced by practitioners' understandings and constructions of their practices of support. The contemporary social and political contexts in which we live are permeated by psycho-medical, humanist, neoliberal, familial, and gender discourses. Therefore, in many ways it is entirely understandable, and even necessary for the continual existence of community-based support services, that facilitators' practices conform to and reinforce these dominant discourses. At the same time, there are many instances in the participants' narratives in which these discourses are challenged and resisted. The participants' practice contexts outside of medical institutions may position them as having less expertise in relations to those with higher statuses within discourses of medicine and psychiatry, yet this also creates space for less prescriptive and less authoritarian ways of working.

Recognizing that there is "no innocence space outside of power" (Healy, 2000, p. 126), poststructuralist theory does not aim to eradicate systems of power in social work but instead seeks to "make visible the potential and actual practices of change in the diversity of practice contexts and obligations" (Healy, 2000, p. 125), even in the authoritarian, medicalized, and increasingly commercialized environments. In the context of eating and body image issues, it is necessary to critique the ways psycho-medical and scientific discourses shape and are reproduced by practices of support "not because science is inherently evil" (Gard, 2009, p. 35), but because the domination of scientific thoughts obscure the historical and social contexts that give shape to both medical treatment models and experiences of distress. The participants' narratives have provided valuable clues as to where we may cultivate and expand the spaces for questioning and change within community-based support services. In several instances the participants talked about contextualizing eating and body image problems around contemporary social issues and various cultural meanings of food and the body. We can push this contextualization further by historicizing the construct of ‘eating disorders’ itself (Boler, 1999). It is important to include the specific histories and genealogical development of diagnoses such as ‘anorexia’ and ‘bulimia’ into our conversations with fellow practitioners, students, clients, and community members. Literature on such histories and genealogies needs to be included in courses and training programs for social workers, counsellors, and therapists, as well as educational and agency websites, community workshops, public lectures, conferences, and support groups, alongside discussions of the ‘signs,’ ‘risk factors,’ and experiences of eating and body image issues, thus grounding these signs and experiences in social and historical contexts and shifting them away from individualizing and pathologizing theories about the self and the family. Exploring the histories of eating and body image issues as psychiatric entities and as social phenomena may also lead to dialogues about issues of gender, race, class, and morality, the hierarchical binaries that prescribe normative femininity and masculinity, the discourses that reach beyond media messages about the body.

Indeed, contradictory expectations for clients have been mentioned throughout the participants’ narratives. Clients, the majority of whom are women, are taught that they need to be “authentic” and at the same time filter their words when expressing emotions; they are constructed as hyper-aware of others’ needs and in need of assertiveness skills, yet at the same time they are positioned as in need of rules to be aware of others and self-regulate their participation in the groups; they are described as unable to regulate their emotional well-being yet at the same time positioned as solely responsible for their own well-being when they feel “triggered” or overwhelmed by emotions. However, the participants’ comments also indicated uncertainties around particular rules, ideals, and outcomes of their group facilitation. They also constructed their practices as shifting away from the prescriptive, authoritarian treatment models in institutional settings. The cultivation of further critical reflections on practices thus necessitates an examination and deconstruction of the concept of the self. Seeing how subjectivities, or the ways individuals see themselves as well as the world, are constituted within discourses and social contexts, rather than perceiving individuals as having intact, fixed, "authentic" selves that are separate from the social world, can challenge the hierarchical binary that position practitioners as 'authentic' and 'normal' and clients as "lacking authentic autonomy" (Moulding, 2006, p. 794) and 'pathological' (Surtees, 2009). In other words, the notion of subjectivities may open up possibilities for practitioners to see that their knowledges, practices, and worldviews "are not exempt from contemporary disciplinary regimes of truth regarding the regulation and disciplinary normalization of bodies" (Surtees, 2009, p. 167) and minds. As Heron (2005) suggests, practitioners' investment in themselves as 'good' practitioner – anti-oppressive, client-centred, nonjudgmental, compassionate, accepting – can preclude an interrogation of how they are inevitably implicated in dominant discourses that oppress, judge, and subjugate. Practitioners' positions as 'experts' in relations of power and their discursive practices of support, such as methods to facilitate the "self-inspection, self-problematization, self-monitoring and confession" (Rose, 1999, p. 11) of emotions, are but parts of the operation of power that reproduces gendered and racialized social norms. Napier and Fook's (2000) discussion of reflective practices may therefore be helpful in facilitating a way to see how our prior learning shapes our seemingly 'intuitive' responses to various practice situations, how theories are produced through our actions, which in turn shape future actions, and how the theories we use, formalized or otherwise, are multiply constituted through histories and discourses. Seeing how points of view, skills, and knowledge as discursively shaped rather than linked to the essential character of the person – for example, one's judgements of clients as shaped by dominant discourses rather than manifestations of one's judgemental personality – may give us the courage to “take risks to expose [our] practice to scrutiny, and so to improve it” (p. 3).

In recognizing that our values and practices are multiply constituted, we may also see that clients’ eating problems are also shaped by multiple stories and in flux depending on contexts rather than fixed, thus creating greater possibilities for change. Narrative therapy, which draws on poststructuralism and Foucauldian philosophy, has been described by critical feminist theorists as a promising alternative to mainstream treatment models in supporting people living with eating and body image problems (Gremillion, 2003; Guilfoyle, 2001). As Epston and Maisel (2009) explain, “[one] of the distinguishing characteristics of narrative therapy is its emphasis on separating the person from the problem through ‘externalizing conversations’. In such a ‘manner of speaking’, considerations of discourse, gender, history and culture can be brought to bear” (p. 212). Such conversations thus challenge the taken-for-granted understanding of eating and body image problems “as residing in and emanating from the disordered ‘self’ of the person” (ibid.) as defined by psycho-medical discourse, thus creating opportunities to engage clients in highlighting and building new meanings around “the contradictions and ruptures that appear within the powerful problems that affect clients’ lives” (Gremillion, 2003, p. 194). Hepworth (1999) argues that narrative therapy continues to operate within the relations of power between client and therapist as defined by the discourses of psychotherapy and psychiatry, which can reinscribe individualizing, disciplinary ‘technologies of the self,’ such as “the confessional” (p. 119) as described by Foucault. As such, she asserts that narrative therapy can reproduce the regulatory and surveillance functions of the psychiatry, thus limiting the social and political analysis and change that can occur. She advocates for practices that move “away from the focus on the clinical management of individual patients” (p. 125) towards “enabling those who are ‘at risk’ of a diagnosis to participate within the broader structure of health care” (ibid.), particularly “in the creation of health care strategies for anorexia nervosa" (ibid.). Healy (2000) warns that egalitarian ideals can impose unrealistic demands on both practitioners and clients, which run the risk of not only minimizing the potentials of local practices for change, but also reinscribing authoritarian practices and the subjugation of individuals' knowledge about their problems. For example, those who are seeking individual care for their emotional distress and the physical consequences of intense weight management practices may not find participation in the creation of health care strategies manageable or helpful. Following Butler (1990), it may be argued that changes to the understanding about eating and body image issues and their interventions do not happen outside of the power relations and practices of dominant psycho-medical discourses; rather, change is *only* possible within the reproduction of these discursive practices through finding ways to subvert the social norms that make the reproduction possible. For instance, Guilfoyle (2001) suggests that, in therapy, the client's refusal to see her eating problems as a psychological problem can be approached as a *political* resistance to the therapist's authority to name her problem rather than a pathological denial of the problem, thus subverting the domination of psychological discourses within client-therapist relationship by taking seriously the client's alternative explanations of her difficulties. Indeed, an integral part of narrative therapy is the documentation of clients' accounts about their understandings, knowledge, and experiences regarding eating and body image difficulties and treatment (Maisel, Epston & Borden, 2004), creating opportunities for clients not only to share knowledge but also to question, challenge, and inform intervention practices. These documents are then offered as support tools for others who are dealing with these difficulties (ibid.), as well as their families, friends, and other professionals, thereby potentially transforming professional and popular understandings and theories about eating and body image issues.

Nevertheless, Hepworth's (1999) criticism of narrative therapy can point to the importance of a "chronic suspicion of who we are and what we are doing" (Rossiter, 2001, p. 2). Community-building has been identified by clients and practitioners alike as generally helpful for individuals' mental health and social actions. However, as analysis of the participants' narratives shows, community and relationship-building based on the notion of shared experiences can reinforce dominant psycho-medical definitions of what counts as 'eating disorder' experiences, exclude those whose experiences seem too different, and incite individuals to define their problems through psycho-medical terms in order to gain a sense of belonging and acceptance. Following Scott (1992), it may be argued that when eating and body image issues become the "overriding identity" (p. 30), individuals' other subject positions and social positioning are subsumed by it, thus obscuring the social inequalities that contribute to eating and body image problems. Emphasis on the therapeutic benefits of relationship-building may also work to regulate or even exclude individuals whose behaviours are thought to threaten relationships of support within the group. The focus on individuals as problems effectively shifts our attention away from the social contexts and norms that shape the interpersonal dynamics in the group. A question may therefore be raised about the extent to which the benefits of specialized support groups can outweigh the groups' potential to essentialize and exclude. The answer to this question is clearly contingent upon the specific contexts in which the groups are held and the histories and subject positions of those who attend and facilitate the group. However, Healy (2000) offers some guidance in suggesting that while "poststructuralists refuse the notion of an essential self as the foundation for shared struggle, collective action remains possible" (p. 54). Collective action in the context of support groups might range from mutual support to social action projects that challenge gender norms. However, she also states that the 'we' in collective-formation and shared activities "is always a provisional category and maintains only in so far as common concerns can be identified" (ibid.), with "the ongoing recognition of difference and so leads to the impossibility of one voice that speaks for all" (ibid.). Flax (1992) advocates that we "need to learn to make claims on our own and others' behalf and to listen to those which differ from ours, knowing that ultimately there is nothing that justifies them beyond each person's own desire and need and the discursive practices in which these are developed, embedded, and legitimated" (p. 460). With the goal of fostering supportive relationships, perhaps instead of attributing challenges in groups to *the problems of individuals*, difficulties, conflicts, and disconnections can be addressed through exploring *the limitations of the group format* in its capacity to meet individuals' diverse needs. Opportunities may then be opened up for practitioners and clients to consider other forms of support that may better suit the clients' needs, or to co-create a kind of community that "foster (among other attributes) an appreciation of and desire for difference, empathy, even indifference in the others" (ibid.). Knowing that empathy may involve a taking-in of others' pain that subsumes others' stories under our own (Boler, 1999), perhaps practices of support can be developed to encourage, as Ahmed (2004) writes, "an ethics of responding to pain [that] involves being open to being affected by that which one cannot know or feel" (p. 30), to "respond to a pain that we cannot claim as our own" (p. 35). Such practices may help to open up the community of support to a diversity of experiences that may or may not be contained within the psycho-medical definitions and categories of 'eating disorders,' thus challenging the legitimacy of dominant discourses and their tendency to reduce and simplify the diversity of human experiences and potentialities to their narrow definitions.

The scope of this research is limited mainly to issues of gender. Understanding that the dominant discourses in our contemporary society is also racialized, classed, and heteronormative, it would be important for future research to examine the discursive constructions of practices and knowledge regarding eating and body image issues with a focus in race, class, or sexuality. It is important to also find ways to invite the participation and leadership of those with experiences of eating and body image issues in research, thus centering their knowledge in the development of resources, services, and practices of support. This study shows that eating and body image issues are only some of the effects of the discourse of gender. ‘Anorexia,’ ‘bulimia,’ and ‘binge eating disorder’ are also frequently diagnosed with other ‘psychopathologies’ such as anxiety and mood disorders (Hudson, Hiripi, Pope & Kessler, 2007). It may therefore be useful to examine the knowledge and practices that are produced through the discursive constructions of these diagnoses and the relationships between them. Such examinations may help to further expose the ways power operates through the discourse of gender (Healy, 2000).

It has been recorded that 20-50% of people who have accessed treatment for eating difficulties terminate treatment early (Masson & Sheeshka, 2009). It has also been documented that 10% of individuals diagnosed with anorexia nervosa die within 10 years of the onset of their eating difficulties (NEDIC, 2014). A major limitation of statistics is that they are often generated from people who have accessed services, which means that there can be many more whose experiences are not accounted for because they do not access services or are deemed ineligible for services. As critical feminist theorists have persistently argued, deaths and prolonged suffering from eating and body image difficulties cannot be attributed solely to individuals’ psychopathology or lack of readiness for change, nor can they be explained simply by the messages in the media, or the shortcomings of treatment or support services. However, deaths, prolonged suffering, and high rates of early termination in support services do indicate that there is a significant number of individuals who do not find existing services supportive, which should compel us as practitioners to incessantly examine our practices and the knowledges that shape them, the ways we are implicated in dominant discourses and networks of power relations, and the ways to disrupt these through expanding the space for alternative knowledges in everyday, local contexts, in order to continually transform our work alongside those we hope to support.

References

Ahmed, S. (2004). *The cultural politics of emotions*. New York: Routledge.

American Psychiatric Association. (2006). *Practice guideline for the treatment of patients with eating disorders* (3rd ed). Washington, DC: Author. Retrieved from http://psychiatryonline.org/pdfaccess.ashx?ResourceID=243187&PDFSource=6

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Black, C. (2003). Creating curative communities: Feminist group work with women with eating issues. *Australian Social Work, 56*(2), 127-140.

Boler, M. (1999). *Feeling power: Emotions and education*. New York: Routledge.

Bordo, S. (1993). *Unbearable weight: Feminism, Western culture, and the body*. Berkeley, CA: University of California Press.

Bordo, S. (2009). Not just ‘a white girl thing’: The changing face of food and body image problems. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 46-60). London: Routledge.

Burns, M. (2004). Eating like an ox: Femininity and dualistic constructions of bulimia and anorexia. *Feminism & Psychology, 14*(2), 269–295.

Burns, M., Tyrer, J., & the Eating Difficulties Education Network. (2009). Feminisms in practice: Challenges and opportunities for an eating issues community agency. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 221-232). London: Routledge.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against*

Women, 9(11), 1293-1317.

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.

Canadian Centre on Substance Abuse. (2013). *When eating disorders and substance abuse problems collide*. Retrieved June 1, 2014 from http://www.ccsa.ca/Resource%20Library/CCSA-Eating-Disorders-and-Substance-Abuse-2013-en.pdf

Chambon, A. S. (1999). Foucault's approach: Making the familiar visible. In A. S. Chambon, A. Irving, & L. Epstein (eds.), *Reading Foucault for social work* (pp. 51-82). New York: Columbia University Press.

Choate, L. (2010). Interpersonal group therapy for women experiencing bulimia. *The Journal for Specialists in Group Work, 35*(4), 349–364.

Epston, D. & Maisel, R. (2009). Anti-anorexia/bulimia: A polemics of life and death. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 209-220). London: Routledge.

Flax, J. (1992). The end of innocence. In J. Butler & J. W. Scott (Eds.), *Feminist theorize the political* (pp. 445-463). New York: Routledge.

Gard, M. (2009). Understanding obesity by understanding desire. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 35-45). London: Routledge.

Gibson, K., O'Donnell, S., & Rideout, V. (2007). The project-funding regime: Complications for community organizations and their staff. *Canadian Public Administration, 50*(3), 1-19.

Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment centre*. London: Duke University Press.

Gringeri, C. E., Wahab, S., & Anderson-Nathe, B. (2010). What makes it feminist?: Mapping the landscape of feminist social work research. *Afflia: Journal of Women and Social Work, 25*(4), 390-405.

Guilfoyle, M. (2001). Problematizing psychotherapy: The discursive production of a bulimic. *Culture & Psychology, 7*(2), 151–179.

Guilfoyle, M. (2009). Therapeutic discourse and eating disorders in the context of power. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 196-206). London: Routledge.

Harper, K. V., & Shillito, L. S. (1991). Group work with bulimic adolescent females in suburbia. *Social Work with Groups, 14*(1), 43-56.

Healy, K. (2000). *Social work practices: Contemporary perspectives on change*. London: Sage.

Healy, K. (2005). *Social work theories in context: Creating frameworks for practice*. New York: Palgrave MacMillan.

Hepworth, J. (1999). *The social construction of anorexia nervosa*. London: Sage.

Heron, B. (2005). Self-reflection in critical social work practice: Subjectivity and possibilities of resistance. *Journal of Reflective Practice, 6*(3), 341-351.

Hudson, J. I., Hiripi, E., Pope, H. G., Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry, 61*(3), 348-358.

Jimenez, M. A. (1997). Gender and psychiatry: Psychiatric conceptions of mental disorders in women, 1960-1994. *Affilia, 12*(2), 154-175.

Ki, P. (2011). Exploring the experiences of participants in short-term art-based support groups for adults living with eating disorders. *Canadian Art Therapy Association Journal, 24*(2), 1-13.

Koski, J. P. (2014). ‘I’m just a walking eating disorder’: The mobilisation and construction of a collective illness identity in eating disorder support groups. *Sociology of Health & Illness, 36*(1), 75-90.

Lazar, M. M. (2005). Politicizing gender in discourse: Feminist critical discourse analysis as political perspective and praxis. In M. M. Lazar (Ed.), *Feminist critical discourse analysis: Gender, power and ideology in discourse* (pp. 1-30). New York: Palgrave Macmillan.

Leavy, P. (2009). *Method meets art: Art-based research practice.* New York: The Guilford Press.

LeBesco, K. (2009). Weight management, good health and the will to normality. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 146-156). London: Routledge.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavioural therapy for patients with borderline personality disorder and drug dependence. *The American Journal on Addictions, 8*(4), 279-292.

Linville, D., Brown, T., Sturm, K., & McDougal, T. (2012). Eating disorders and social support: Perspectives of recovered individuals. *Eating Disorders: The Journal of Treatment & Prevention, 20*(3), 216-231.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York: W. W. Norton & Company.

Malson, H. & Burns, M. (2009). Re-theorising the slash of dis/order: An introduction to critical feminist approaches to eating dis/orders. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 1-6). London: Routledge.

Malson, H. (2009). Appearing to disappear: Postmodern femininities and self-starved subjectivities. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 135-145). London: Routledge.

Malson, H., & Ryan, V. (2008). Tracing a matrix of gender: An analysis of the feminine in hospital-based treatment for eating disorders. *Feminism & Psychology, 18*(1), 112–132.

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder'. *European Eating Disorders Review, 19*(1), 25–36.

Malson, H., Clark, S., & Finn, M. (2007). 'I don't think that's normal': A reflection on accounts of experiences of treatment for eating disorders. *Feminism & Psychology, 17*(4), 417–424.

Masson, P. C. & Sheeshka, J. D. (2009). Clinicians' Perspectives on the premature termination of treatment in patients with eating disorders. *Eating Disorders: The Journal of Treatment & Prevention, 17*(2), 109-125.

McVey, G. L., Davis, R., Kaplan, A. S., Katzman, D. K., Pinhas, L., Geist, R., Heinmaa, M., & Forsyth, G. (2005). A community-based training program for eating disorders and its contribution to a provincial network of specialized services. *International Journal of Eating Disorders, 37*(S1), S35-40.

McVey, G. L., Davis, R., Tweed, S., & Shaw, B. F. (2004). Evaluation of a school-based program designed to improve body image satisfaction, global self-esteem, and eating attitudes and behaviors: A replication study. *International Journal of Eating Disorders, 36*(1), 1-11.

McVey, G. L., Lieberman, M., Voorberg, N., Wardrope, D., & Blackmore, E. (2003). School-based peer support groups: A new approach to the prevention of disordered eating. *Eating*

Disorders: The Journal of Treatment & Prevention, 11(3), 169-185.

Morrow, M. (2013). Recovery: Progressive paradigm or neoliberal smokescreen? In B. A. LeFrançois, R. Menzies & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 323-333). Toronto: Canadian Scholars' Press.

Moulding, N. & Hepworth, J. (2001). Understanding body image disturbance in the promotion of mental health: A discourse analytic study. *Journal of Community & Applied Social Psychology, 11*(4), 305-317.

Moulding, N. (2006). Disciplining the feminine: The reproduction of gender contradictions in the mental health care of women with eating disorders. *Social Science & Medicine, 62*(4), 793-804

Napier, L, & Fook, J. (2000). Reflective practice in social work. In L. Napier & J. Fook (Eds.), *Breakthroughs in practice: Theorizing critical moments in social work* (pp. 1-15). London: Whiting and Birch.

Nasser, M., & Malson, H. (2009). Beyond western dis/orders: Thinness and self-starvation of other-ed women. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 74-86). London: Routledge.

National Eating Disorder Information Centre [NEDIC]. (2014). *Statistics*. Retrieved June 1, 2014 from http://www.nedic.ca/know-facts/statistics

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.

Perspectives of male eating disorder service-users. *Journal of Health Psychology, 18*(2) 176-186.

Piran, N. (2010). A feminist perspective on risk factor research and on the prevention of eating disorders. *Eating Disorders: The Journal of Treatment & Prevention, 18*(3), 183-198.

Robinson, K. J., Mountford, V. A., & Sperlinger, D. J. (2013). Being men with eating disorders:

Rose, N. (1999). *Governing the soul: The shaping of the private self*. London: Free Association Books.

Rossiter, A. (2001). Innocence lost and suspicion found: Do we educate for or against social work? *Critical Social Work, 2*(1), 1-6.

Rossiter, A. (2005). Discourse analysis in critical social work: From apology to question. *Critical Social Work, 6*(1), 1-10.

Saukko, P. (2009). A critical discussion of normativity in discourses on eating disorders. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 63-73). London: Routledge.

Sayers, J. (2009). Feeding the body. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 22-34). London: Routledge.

Scott, J. W. (1992). Experience. In J. Butler & J. W. Scott (Eds.), *Feminist theorize the political* (pp. 22-40). New York: Routledge.

Silverman, D. (2013). *Doing qualitative research* (4th ed.). London: SAGE Publications.

Staples, N. R. & Schwartz, M. (1990). Anorexia nervosa support group: Providing transitional support. *Journal of Psychosocial Nursing & Mental Health Services, 28*(2), 6-8, 10.

Surtees, R. (2009). Food for thought: Embodied slimness and nursing within an eating disorder unit. In H. Malson and M. Burns (Eds.), *Critical feminist approaches to eating dis/orders* (pp. 159-171). London: Routledge.

Van Dijk, T. A. (1993). Principles of critical discourse analysis. *Discourse and Society, 4*(2), 249-283.

Wanlass, J., Moreno, J. K., & Thomson, H. M. (2005). Group therapy for eating disorders: A retrospective case study. *The Journal for Specialists in Group Work, 30*(1), 47–66.

Weber, M., Davis, K., & McPhie, L. (2006). Narrative therapy, eating disorders and groups: Enhancing outcomes in rural NSW. *Australian Social Work, 59*(4), 391-405.

White, M. (2001). Folk psychology and narrative practice. *Dulwich Centre Journal, 2*, 1-37.

Wilson, G.T., Grilo, C.M., & Vitousek, K.M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199-216.

Witkin, S. L., & Harrison, W. D. (2001). Whose evidence and for what purpose? *Social Work, 46*(4), 293-296.

Woolhouse, M., Day, K., Rickett, B., & Milnes, K. (2011). 'Cos girls aren't supposed to eat like pigs are they?' Young women negotiating gendered discursive constructions of food and eating. *Journal of Health Psychology, 17*(1), 46-56.

Yager, Z. & O'Dea, J. (2008). Prevention programs for body image and eating disorders on university campuses: a review of large, controlled interventions. *Health Promotion International, 23*(2), 173-189.

Zimmerman, G. L., Olsen, C. G., & Bosworth, M. F. (2000). A 'stages of change' approach to helping patients change behavior. *American Family Physician, 61*(5), 1409-1416.

Zimpfer, D. G. (1990). Group work for bulimia: A review of outcomes. *The Journal for Specialists in Group Work, 15*(4), 239-251.

Appendix >: Data Collection Instrument – Interview Questions

The participants will first be invited to participate in a 15-minute arts-based exercise, in which they are invited to use collage images, drawings, and/or words to express the kind of support that they hope to facilitate in a support group for adults living with eating and body image issues (art supplies will be provided).

When interview is conducted by phone or Skype, the art-based exercise is omitted, and the following question is asked instead:
What words or images come to mind when you think about the kind of support that you wish to facilitate in a support group for adults living with eating and body image issues?

The following open-ended interview questions will be asked. Specific prompts are listed to ensure that I ask about issues that are important to the research if the participants do not raise those issues themselves. Additional questions may be asked in response to the participants' answers to encourage them to elaborate on salient points.

1. Can you tell me about the image you have created, in terms of the kind of support that you hope to facilitate in the groups, or what support means to you as a group facilitator?
2. How long have you been facilitating support groups for people living with eating and body image problems?
3. How might you describe your current approach to practice in facilitating support groups?
4. What had led you to this understanding about support and your approach to practice?
    - Professional theories and knowledge, or specific practice models?
        - What drew you to these specific theories or models over others?
    - Values, experiences, principles or beliefs?
    - Peer support, training and supervision?
5. How do you see your work in a community-based setting relate to hospital treatment programs?
6. Do you think issues of gender should be taken into account when facilitating support in groups? If so, how? What had led you to this understanding or point of view?
7. Do you think issues of racial or cultural diversity should be taken into account when facilitating support in groups? If so, how? What had led you to this understanding or point of view?
8. Can you tell me about a time when your approach has made a difference for someone in a group you facilitated?
9. Can you tell me about a time when your approach doesn't seem to work for you or the group?
10. What are your hopes for community-based support for people living with eating and body image issues? What might you suggest to enhance community-based support services?

Appendix B: Informed Consent Form

Study name

What do we mean by support? Exploring discursive practices in the facilitation of community-based support groups for adults living with eating and body image issues

Researchers

Researcher name Patricia Ki

Masters Candidate

Graduate Program in Social Work

Email address ki.patricia@gmail.com Office phone 416 882 1896

Purpose of the research

This study aims to explore practitioners's experiences and practice approaches in the facilitation of support groups in non-treatment, community-based settings for adults living with eating and body image difficulties. Research on eating and body image issues often focus on hospital-based interventions. By exploring community-based support through the framework of discourse analysis, this study hopes to open up new possibilities in direct service, prevention, and advocacy that address the social and political issues implicated in eating and body image problems. The results of the study will be reported in a Practice Research Paper in partial fulfillment of the requirements for the degree of Master of Social Work at York University. A summary of the findings can also be sent to the participants if they wish.

What you will be asked to do in the research

You will be invited to discuss your experiences and practice approaches in facilitating support groups for adults living with eating and body image issues, and to participate in a 15-minute art-based exercise that aims to assist in our discussion about abstract concepts, such as support, in a creative way. You are invited to participate to the extent that you feel comfortable. The interview will last approximately 1.5 hours and take place at a mutually convenient time and location. Reimbursement for public transportation will be provided if applicable.

Risks and discomforts

We do not foresee any significant risk from your participation in this study, aside from the possibility that discussions about one's approaches to providing support may be related to and bring up memories of one's past experiences of being in need of support. Should you experience emotional discomfort in reaction to the interview questions, you may stop the interview at any time, and if you wish I can assist you with accessing immediate support or other support services of your choosing.

Benefits of the research and benefits to you

The interview can be an opportunity to reflect on your professional practice in a new and creative way through the art-based exercise and the discussion that follows. I can provide a summary of the findings with insights from practitioners working in different disciplines. The participants' insights will be used to generate new ideas to enhance support services for people living with eating and body image difficulties.

Voluntary participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

If you decide to stop participating, you will still receive reimbursement for the cost of public transportation if applicable. Any information you provide can be changed or removed upon your request until May 1, 2014.

Confidentiality

The interview will be audio-recorded and transcribed, and handwritten notes will be taken during the interview. The artwork created will be photographed and included in the final report. You may decline to have photographs taken of your artwork. The recordings and transcripts will be stored on my computer in a password-protected folder, and notes in a locked cabinet in my home, for up to 5 years for the purpose of potential future research. In the transcripts and final report all personally identifying information will be removed, with each participant being represented by a single letter. Only I will have access to the recordings, notes and transcripts. Digital data will be erased and notes shredded after January 2019.

Confidentiality will be provided to the fullest extent possible by law.

Questions about the research?

If you have questions about the research in general or your role in the study, please don't hesitate to contact me or my supervisor, Dr. Susan McGrath, by email at smcgrath@yorku.ca or by phone at 416-736-2100 ext. 66662. You can also contact the graduate program at the School of Social Work by email at gradsowk@yorku.ca or by phone at 416-736-2100 ext. 22656.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, your may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone 416-736-5914 or e-mail ore@yorku.ca

Legal rights and signatures:

I, , consent to participate in

What do we mean by support? Exploring discursive practices in the facilitation of community-based support groups for adults living with eating and body image issues

conducted by Patricia ki . I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature ____________________ **Date** ________________
Participant

Signature ____________________ **Date** ________________
Principal Investigator

YORK UNIVERSITY GRADUATE STUDENT HUMAN PARTICIPANTS RESEARCH PROTOCOL

Student Name: Patricia Ki **Date:** Jan. 14, 2014

E-mail: ki.patricia@gmail.com **Phone Number:** 416 882 1896

Program: Social Work **Degree:** Master of Social Work

Check one: ☐ **Thesis** ☐ **Dissertation** ■ **Major Research Paper** ☐ **Course**

Title: What do we mean by support? Exploring discursive practices in the facilitation of community-based support groups for adults living with eating and body image issues

Name of Supervisor (Thesis, Dissertation or MRP) or Course Director:

PART A - GENERAL INFORMATION

1. Is the research you are conducting funded?

No ● Yes ○

The definition of "funded" does not include funding in the form of student OGS scholarships, SSHRC fellowships, NSERC scholarships, or CIHR studentships. These awards are intended to support students through their studies and do not require reports from students on the specific research activities conducted. The definition of "funded" does apply to grants awarded for specific research projects, whether those projects be the student's own research projects or research being conducted as part of a faculty member's funded research project. Typically, for funded research, granting agencies require reports of the research conducted.

2. Is this a revised version of a protocol previously submitted to FGS (and/or HPRC)?

No ● Yes ○ If yes, please explain.

PLEASE DO NOT SUBMIT YOUR PROPOSAL TO THE HPRC OFFICE

For Thesis or Dissertation this protocol must be submitted to the Office of the Dean, Graduate Studies accompanied by *Thesis/Dissertation Proposal Submission Form (i.e. TD1)* and your thesis/dissertation proposal.

In cases requiring preliminary research, this protocol must be submitted to the Office of the Dean, Graduate Studies accompanied by *Thesis/Dissertation Proposal Submission Form (i.e. TD1)* and your research proposal. Please indicate on the TD1 form that your research is a pilot study, or preliminary research.

PART B: RESEARCH INFORMATION

1. Are the risks to participants more than minimum risk*?

No ● Yes ○

*The Human Participants Research Committee uses the definition of minimal risk as outlined in the SSHRC/NSERC/CIHR *Tri-Council Policy Statement "Ethical Conduct for Research involving Humans"* (August 1998): "If potential subjects can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research then the research can be regarded as within the range of minimal risk" (p. 1.5). An expanded version of this definition is available from the Office of Research Ethics (5th Floor, York Research Tower) upon request.

2. Project Description and Rationale:
In layperson's terms, please provide a general and very brief description of the research and rationale (e.g., hypotheses, goals and objectives etc.)

Description:
The purpose of the research is concerned with the ways service providers define, construct, and understand their practices and approaches in facilitating support groups for adults living with eating and body image difficulties in non-hospital, non-treatment, community-based settings. Through a critical feminist perspective and the framework of discourse analysis, it aims to identify the discourses (i.e. social norms, values, beliefs, and practices) and power relations that give shape to and are shaped by the ways facilitators discuss their practices.

Semi-structured interviews will be conducted with four to five service providers who have experiences in facilitating community-based support groups for people living with eating and body image issues. The interview will also involve a 15-minute art-based exercise that aims to assist in the reflection and discussion of abstract concepts such as support in a creative way. The data will be analyzed through the framework of discourse analysis. No analysis of the artwork will be made beyond what the participants say about them.

Rationale:
Feminist theorists argue that eating and body image problems are constructed within contemporary Western cultural discourses, particularly those regulating gender norms for women (see for example Malson & Ryan, 2008). Moreover, they critique that mainstream treatment, which is mostly based on a Eurocentric psycho-medical model and focuses on individual and family dysfunctions, often reinforce the cultural norms and values that give rise to eating and body image problems in the first place (ibid.). Critical analyses of practitioners' approaches in both individual and group interventions mostly focus on hospital-based treatment (see for example Burns, 2004, and Hepworth, 1999); community-based support groups seem to be an under-explored area of study. However, it is an important area to examine because they are often more accessible in regard to wait time and cost than hospital-based treatment and private therapy (Ki, 2011) Therefore, these groups can be alternative options for people who are not able to afford private treatment, on a wait list, deemed ineligible for treatment, or choosing not to use hospital treatment (ibid.). Social workers often work as group facilitators in community-based support centres, including those specialized in eating and body image difficulties. As professionals in positions of power, we as direct service providers participate in the production of knowledge about the people we claim to support through the language we use to name and define their behaviours, needs, and our corresponding practices (Chambon, 1999). Examining the ways that group facilitators understand and define their practice approaches through a critical feminist perspective and discourse analysis may open up new possibilities in direct service, prevention, and advocacy to disrupt the discourses and power relations that contribute to eating and body image problems.

Burns, M. (2004). Eating like an ox: Femininity and dualistic constructions of bulimia and anorexia. Feminism & Psychology, 14(2), 269–295.
Ki, P. (2011). Exploring the experiences of participants in short-term art-based support groups for adults living with eating disorders. Canadian Art Therapy Association Journal, 24(2), 1-13.
Malson, H., & Ryan, V. (2008). Tracing a matrix of gender: An analysis of the feminine in hospital-based treatment for eating disorders. Feminism & Psychology, 18(1), 112–132.

3. Participants:
   a. State who the participants will be (e.g. experimental subjects, interviewees, community members to be observed, etc.). Please provide details about the research subjects that are relevant to your particular research (number, age, sex, students, children, businesspeople, government employees, etc). Also discuss the relationship of the researchers to the prospective subjects (e.g. teacher, parent, advisor, stranger, etc.):

The participants will be practitioners who have experience in facilitating support groups for adults living with eating and body image issues in community-based, non-treatment settings, such as community-based agencies, specialized support centres or schools. Since the vast majority of service providers working in the area of eating and body image issues are women, the participants will likely be adult women. They will be social workers and practitioners from various disciplines, such as creative therapies and counselling psychology. Four or five practitioners will be interviewed. Some of the interviewees will be acquainted to me (the researcher) through work; however, to improve the validity of this study, I will not interview practitioners I have worked closely with, such as those who have co-facilitated groups with me. I also hope to interview practitioners I do not personally know.

   b. How will the participants be recruited (e.g., snowball technique, random sampling, previously known to the interviewer, telephone solicitation, etc)?

Due to time constraints, I plan to use a convenient sampling method by contacting two facilitators I am acquainted with through my employment at Sheena's Place, a Toronto-based support centre for people living with eating and body image issues. However, to increase the diversity in perspectives, I will also use a snowball technique to contact facilitators who do not work at the same support centre by asking for recommendations from those I am acquainted with. I have also found a poster for a 'disordered eating and body image' support group at York University, and I plan on emailing the two facilitators listed on the poster. I may also identify potential participants on agency websites or promotional materials for other support groups and contact them through email. A sample email invitation is attached.

c. Will you be offering inducements to participate (e.g., money, gift certificates, academic credit, etc.)?
No ○ Yes ● (If yes, please elaborate)

Reimbursement for travelling costs (i.e. TTC tokens, cash for YRT) will be provided if participants are traveling by public transportation to come to the interviews.

d. What exactly will be required of the participants (e.g., answer a formal questionnaire, respond to interview questions, engage in a free-ranging discussion, undergo any medical procedures, etc.)? If applicable, please attach any research instruments (e.g., sample interview questions, questionnaires, etc.

The participants will first be invited to participate in a 15-minute arts-based exercise, in which they are invited to use collage images, drawings, and/or words to create an image that represent the kind of support they hope to facilitate in a support group for adults living with eating and body image issues (art supplies will be provided).

The participants will then be invited to discuss the image they have created. Open-ended interview questions will be asked (please see attached sample questions). Additional questions may also be asked in response to the participants' answers.

Each interview is expected to be approximately 1.5 hours in length and will take place at a mutually convenient time and location. The interviews will be audio recorded and transcribed verbatim for analysis. Notes will also be taken during the interviews. If participants share information when the recording device is switched off, I will ask permission to make note of and include the shared information in the analysis.

4. Risks and Benefits:

a. What are the risks to the participants?

Participants' understanding of support might be linked to their own experiences of being in need of support. As such, the interview questions might lead to the participants disclosing their past experiences of various difficult issues. However, because the participants are service providers, it is assumed that they would have processed at least some of their difficult issues and have the skills to discern what to share and what to withhold in order to maintain a sense of safety for themselves.

Nevertheless, with my own professional experiences and skills in working with people who have experienced trauma, mental health concerns and other emotionally distressing situations, I believe that I have the sensitivity required to discern when I should check in with the participants if they seem overly emotional or upset. The participants will also be assured that they can stop the interview at any time and there will be no penalties for doing so. I will assist the participants to access immediate support (i.e. crisis line, calling a trusted person or a taxi home) or other support services if they so require.

b. What are the benefits to the participants?

The interview can create an opportunity for the participants to reflect on their own approach to practice in a new and creative way through the art-based exercise and the ensuing discussion. If the participants are interested, I can also provide them with a brief summary of the findings, with insights from practitioners working in different disciplines and analysis through a discursive analytic lens and a critical feminist perspective, which may be useful for enhancing their practices. The participants' insight will also lead to recommendations for direct practice, program development, and advocacy in community-based settings, thus contributing to new ideas for developing services that take into account social and political contexts in the development of eating and body image difficulties.

Part C: This section pertains to issues around informed consent. Before completing, please read “Important Statement Regarding Informed Consent” attached to the end of this form.

1. Will you provide a full explanation of the research to the participants prior to their participation?

Yes ● No ○ (If NO, please elaborate)

2. Is substitute consent involved (e.g., for children, youths under 16, incompetent adults)?

Yes ○ No ●

3. Is deception involved?

Yes ○ No ● (If YES, please elaborate below. Please comment on debriefing, if applicable.)

4. Will individuals remain anonymous?
Please note that it is expected that participants remain anonymous unless they have given their prior written consent.)

Yes ● No ○ (If NO, please elaborate below.

5. Will the data be kept confidential?
   Please note that it is expected that the data will be kept confidential unless the participants have given their permission otherwise. Please also note that if you advise participants that the data will be confidential, you should state that confidentiality will be ensured, within the limits of the law.)

   Yes ● No ○ (If NO, please elaborate below).

6. How will data be securely stored and for how long?

The recordings, transcripts, and photographs of the participants' artwork will be stored on my computer in a password protected folder, and handwritten notes in a locked cabinet in my home, for up to 5 years for the purpose of potential future research. Photographs of artwork will be included in the final report; this will be specifically pointed out to participants and they may decline to have their artwork photographed. In the transcripts and final report all personal identifying information will be removed, and each participant will be represented by a single letter. Only I will have access to the recordings and transcripts of the interviews.

7. Please also indicate for how long the data will be securely stored and what will happen to the data after the retention period, that is, will it be destroyed or archived)if archived, indicate where)

The recordings, transcripts, and photographs of the participants' artwork will be stored on my computer in a password protected folder and handwritten notes in a locked cabinet in my home. Any information, including images, that the participants have provided can be changed or removed upon their request until May 1, 2014, to leave adequate time for me to make changes to the final paper before its first draft is due on May 20, 2014. The digital data will be erased and notes shredded after January 2019.

8. How will informed consent be obtained? (Check one)

   ☑ Written Informed Consent Document (Please attach draft version)

   ☐ * Letter (please attach draft version)

   ☐ * Oral Informed Consent Document (Permissible only in extenuating circumstances, where written communication is not feasible; draft script of oral informed consent must be provided)

*If informed consent is being obtained by letter or verbally, please provide a rational regarding why an informed consent form is not being used.

Appendix B provides a checklist for the content of the Informed Consent Document.

9. If you have previously received approval for a research ethics protocol, please attach documentation, as appropriate.

STUDENT DECLARATION

I hereby certify that all information on this form and all statements in the attached documentation are correct and complete. I understand that all human participants in the research must have signed a written consent form or have provided oral consent for their participation in the research. I understand that should there be any change in the research methodology or any increased anticipated risks to human participants, I will advise the Faculty of Graduate Studies; if these changes are not minor, my research proposal may be required to undergo a further ethics review. I understand that any misrepresentation in the proposal or attached documentation may lead to a charge of breach of academic honesty. I also understand that I must retain Consent Forms for two years following the completion of the research.

______________________________	_____Jan.14, 2014__________
Student's Signature	Date

SUPERVISOR DECLARATION

I hereby certify that all information on this form and all statements in the attached documentation are correct and complete. I have advised the student that, as specified in Item 6 above and in attached documentation, all human participants in the research must have signed a written consent form or have provided oral consent for their participation in the research. I have advised the student that the Faculty of Graduate Studies will be advised of any changes in research methodology or any increased anticipated risks to human participants and that a further ethics review may be required as a result of such changes. I have advised the student that Consent Forms must be retained for two years following the completion of the research.

☐ A TCPS tutorial certificate dated within the past 2 years is attached

______________________________	______________________________
Signature of supervisor (of Thesis, Dissertation, or MRP) or Course Director	Date

PANEL ON
RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Patricia Ki

has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **18 September, 2013**