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Psychosocial interventions in feeding and eating disorders: the experience of arts on prescription and museum visits

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ABSTRACT

This review summarizes the principal aspects of psychosocial interventions in mental health problems and in detail in Feeding and Eating Disorders. Feeding and Eating Disorders represent a major public health problem and therefore it is necessary to maximize therapeutic and preventive efforts. Social prescribing, a mechanism for linking patients in primary care with non-medical sources of support within the community social factors, may represent a good strategy to cope with social factors involved in the onset and the maintenance of the disorder in order to ensure long-term effectiveness. Arts on prescribing and Museum on prescribing defined as the use of artistic activities or museum visits for therapeutic purposes seem particularly suitable interventions in patients with Feeding and Eating Disorders.

RIASSUNTO

L'articolo qui presentato intende fare una rassegna dei principali aspetti connessi agli interventi psicosociali nell'ambito della salute mentale, nello specifico in merito ai Disturbi Alimentari. Questi ultimi sono diventati un problema di salute pubblica e dunque si prospetta la necessità di massimizzare gli interventi preventivi e terapeutici a riguardo. La prescrizione sociale, meccanismo che permette di collegare i pazienti delle cure primarie con fonti di supporto non mediche, quali interventi in ambito sociale e comunitario, può rappresentare una buona strategia per far fronte ai fattori sociali coinvolti nell'insorgenza e nel mantenimento del disturbo al fine di garantire una lunga durata dell'efficacia dell'intervento. In particolare vengono qui descritti interventi e prescrizioni quali fruizione di attività artistiche o visite museali a fini terapeutici. Questi sembrano essere interventi particolarmente indicati nei pazienti con Disturbi dell'Alimentazione.

KEYWORDS

Feeding and Eating Disorder, social prescribing, museum, artwork.

PAROLE CHIAVE

Disturbi dell'Alimentazione, prescrizioni sociali, museo, arte.

Psychosocial intervention in Mental Health

The Consolidated Standards of Reporting Trials for Social and Psychological Interventions (CONSORT – SPI) defined Psychosocial Intervention in mental health

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such as interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of improving health functioning and well-being.

It has been pointed out that this definition emphasized three aspects: actions, mediators and outcomes. Actions refer to specific activities, techniques or strategies that are by definition interpersonal in nature or carried out through the presentation of information; they could be generic or specific and the latter based on appropriateness for a particular theoretical approach. Through mediators, interventions are translated into outcomes and this happens because changes in biological, psychological and environmental factors are solicited. Outcomes are defined as expected changes in a number of domains including; physical and mental health symptoms; daily living, community, school/work and relationship functioning and well-being that consist in quality of life, recovery and self-determination (England, Butler, Gonzalez, Institute of Medicine (U.S.). Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders, & Institute of Medicine (U.S.). Board on Health Sciences Policy, 2015). In Mental Health psychosocial interventions encompass not only reduction in symptoms but also changes in psychological states such as beliefs, self – esteem or emotions, investment in social relationships and sense of belonging to the community, improvement of school/work functioning, improvement of the quality of life. Precisely for this reason psychosocial interventions are actions that go beyond the bio-medical model of mental illness. Furthermore, social factors such as family or community factors can play a risk or protective role, for example lack of significant relationship and social isolation were well recognized risk factors whereas high quality relationship with open communication and community/social network support were protective factors (Misra, 2018). In the framework of global mental health research and in quantitative studies psychosocial interventions have demonstrated efficacy in the improvement of symptoms, functioning, quality of life and social inclusion related to mental health problems. Many studies highlighted the positive effect of psychosocial interventions in Schizophrenia, Depression, Bipolar Disorder, Post Traumatic Stress Disorder (PTSD), Substance Abuse Disorder and Eating Disorders (Costa & Melnik, 2016; De Silva, Cooper, Li, Lund, & Patel, 2013; Dutra et al., 2008; Kell & Haedt, 2008; Nosè et al., 2017; Reinares, Sánchez-Moreno, & Fountoulakis, 2014). Qualitative approaches to psychosocial interventions in mental health research provide information on settings, providers, populations, elements of therapeutic change, standards, quality of care. Psychosocial interventions originate from a wide variety of approaches and include different types of intervention; examples are: psychotherapies; community-based treatment; vocational rehabilitation; peer support service and integrated care interventions (England et al., 2015). A growing line of research is represented by Social prescribing, a mechanism for linking patients in primary care with non-medical sources of support within the community (Scottish Development Centre for Mental Health, 2014).

Social prescribing and Arts on prescription

The CentreForum Commission in the report 'The Pursuit of Happiness: A New Ambition for our Mental Health' indicate that Social prescribing …might include opportunities for arts and creativity, physical activity, learning new skills,

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volunteering, mutual aid, befriending and self-help, as well as support with, for example, employment, benefits, housing, debt, legal advice, or parenting problems… social prescribing is helpful for vulnerable and at risk groups…; people with mild to moderate depression and anxiety; people with long-term and enduring mental health problems… (Centre Forum Mental Health Commission, 2014)

The Scottish Development Centre for Mental Health in the report "Developing Social Prescribing and Community Referrals for Mental Health in Scotland" pointed out that social prescribing provides an alternative response for mental distress and create a further opportunity to improve the possibility of first line treatment to respond adequately to mental health symptoms. Social prescribing might reduce prevalence of common mental health disorders, improve mental health outcomes and community wellbeing and promote social inclusion (Scottish Development Centre for Mental Health, 2014).

The term prescribing derived from medicine and indicates its potential to have positive effect on psychological health. Nowadays the interest is growing in that form of interventions and number of programs are increased (Bungay & Clift, 2010).

In United Kingdom (UK) The National Academy of Social Prescribing has been established by the Secretary of State for Health and Social Care in order to develop and promote social prescribing for mental health. Chatterjee et al have recently summarized models of social prescribing in a systematised review. They included: "Arts on Prescription"; "Books on Prescription"/"Bibliotherapy"; "Education on Prescription"; and "Exercise Referral/Exercise on Prescription"; … "Green Gyms" and other "Healthy Living Initiatives"; Sign Posting'/"Information Referral"; "Supported Referral"; and "Time Banks" (Chatterjee, Camic, Lockyer, & Thomson, 2018).

In particular, Arts on prescription (AoP) refer to any programme or workshop that use arts to support patients with mental and physical health problems. The first program of AoP started in Stockport in 1994 and included a series of activities to people with depression (Bungay & Clift, 2010). In the 2014 the UK all Party Parliamentary Group on Wellbeing Economics (APPG/WE) acknowledged the importance of these art programmes in health and well-being (APPG/WE, 2014). The positive effect has been associated with the opportunity of self-expression, social contact and participation; program participants reported reduction in feeling of social exclusion and isolation (Hacking, Secker, Spandler, Kent, & Shenton, 2008).

Psychosocial intervention in Feeding and Eating Disorders.

Feeding and Eating Disorders (FEDs) represent a public health problem characterized by significant impairment in adolescence and in young people. The Diagnostic and Statistical Manual of Mental Disorder has reclassified the diagnostic category including: anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), avoidant/restrictive food intake disorder (ARFID) and other specific feeding or eating disorder (OSFED). An is a condition characterized by persistent reduction in food assumption, intense fear of gaining weight or becoming fat (or persistent behavior that interferes with weight gain) and the presence of a significant alteration in self-perception related to weight and body shape. Commonly AN begins during adolescence or early adulthood, the course of the

disease is highly variable but very often it is chronic and/or relapsing. Mortality rate is high (5% per decade, medical causes or suicide) (American Psychiatric Association, 2013). AN is more common in females, with a lifetime prevalence of 1.4% (0.1 – 3.6%) (Galmiche, Déchelotte, Lambert, & Tavolacci, 2019). BN includes binge eating episodes and inappropriate compensatory behaviors such as vomiting, laxative use, fasting, or excessive exercise. Binge eating episodes are characterized by eating a large amount of food in a short time and/or feeling out of control. In BN, the weight and body shape influences self-esteem levels. BN lifetime prevalence is 1.9 (0.3 – 4.6%) in female (Galmiche et al., 2019). ARFID indicates the presence of eating disturbances in infancy and early childhood, characterized by lack of interest in food and eating, avoidance based on the sensory characteristics of food and fear of possible negative consequences of eating (e.g., choking, vomiting) associated with medical, nutritional, and/or psychosocial impairment (Brigham, Manzo, Eddy, & Thomas, 2018). OSFED is a condition in which there are feeding or eating symptoms that causes distress or impairment but the diagnostic criteria are not meet (American Psychiatric Association, 2013). An Australian epidemiological study on FEDs included also ARFID and OSFED and it found a prevalence of 0.3% and 3.2% respectively (Hay et al., 2017). A key role in the management of the FEDs is represented by the indications of the international guidelines on evidence-based treatments including those relating to the National Institute for Health and Care Excellence (National Institute for Health and Care Excellence (NICE), 2017). In general, the treatments are multi-modal, multidisciplinary and distributed on different levels of assistance based on clinical severity. The psychosocial meaning attributed to the treatment of the FEDs indicates the need for address various features of the disorder and moreover the importance to involve both psychological and social factors involved in the onset and the maintenance of the disorder in order to ensure long-term effectiveness. Two reviews analyzed the evidence-based effectiveness of the psychosocial treatments for FEDs (Costa & Melnik, 2016; Keel & Haedt, 2008).

Psychological, Psychoeducational and pharmacological therapy are available. Psychological therapies are Cognitive Behavior Therapy – Enhanced (CBT-E), Family-based treatment (FBT), the Maudsley Anorexia Nervosa Therapy for Adults (MANTRA), Specialist Supportive Clinical Management (SSCM) and Focal Psychodynamic Therapy (FPT). All these therapies are associated with psychoeducation about physical health, nutritional advice and correct eating habits. Pharmacological treatments represent a new strategy for the treatment of AN, BN and BED and include the use of second-generation antipsychotics and SSRIs with several clinical trials that have demonstrated their efficacy in these populations (Hay, 2020).

Table 1 summarized Nice Guidelines treatments for AN, BN and BED in adults, children and adolescents

Table 1 around here

The American Academy of Child and Adolescent Psychiatry in the practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders suggest that outpatient psychosocial interventions are the first treatment of choice for children and adolescents with eating disorders (Lock, La VIa, & (CQI). 2016).

In Italy, indications deriving from evidence based psychosocial treatments have been collected in the document "clinical, structural and operational

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appropriateness in the prevention, diagnosis and therapy of eating disorders" of the Ministry of Health (Ministero della Salute, 2013).

It is beyond the scope of this paper to analyze in detail the characteristics of each individual treatment but it is very useful to note that these treatments do not aim exclusively at physical and psychological well-being but address a series of objectives of a more broadly psychosocial nature. They are: psychoeducation, monitoring of risk factors, coordination between services, involve the person's family members, develop quality of life changes, improve social skills and enhance self-esteem and self-efficacy, encourage the person's independence taking into account the person's specific developmental needs, minimize the risk of relapse.

Arts on prescribing and Museum visits in Eating Disorders

A wide range of interventions, non-medical or psychological in nature could encourage the person with FEDs to understand how symptoms influence the person's relationship with other and the wider social context and definitely contribute to develop a "non-anorexic/bulimic identity". Arts on prescribing might increase the aptitude of primary care to respond early and successfully to symptoms of mental distress, as well as initiating a positive attitude to mental health improvement (Scottish Development Centre for Mental Health, 2014). Secker et al. in a major national project on arts, mental health and social inclusion found that arts participation had positive effect on level of empowerment and social inclusion in people with mental health problems; in this program the artistic commitment has helped participants to build social relations (Secker, Hacking, Spandler, Kent, & Shenton, 2007). There is an increasing evidence that visit to Museums (Museum on Prescription - MoP) has benefit on health and quality of life, wellbeing, learning and social inclusion. A program in several central London and Kent museums with 115 adult participants at risk for social problems, found significant health improvements. The museum activities offered opportunities to meet other people and ascertain new information and skills (Thomson, Lockyer, Camic, & Chatterjee, 2018). A recent study combined creative, arts-based activities and green activity outdoors using a mixed method of analysis (qualitative-quantitative). Qualitative data were obtained from researcher and facilitator observations; interviews with participants, facilitators and volunteers; and structured diary entries from participants and facilitators. The inductive thematic analysis revealed three fundamental themes: 1) building a sense of community; decreasing social isolation and supporting self-esteem. Quantitative findings showed that the program increased total score of wellbeing ($t(19) = 6.96$, $p < .001$) and mood items (especially excited and inspired). Creative art therapies have been used in FEDs. They have the potential to give voice to unexpressed, uncover stories, feelings, and experiences, create space for change and transformation, and allow for new meaning to emerge… art, dance, drama and poetry therapies may have the potential to promote insights, growth and recovery (Heiderscheit, 2016). Art therapy and psychodrama can support routine group therapies as they bypass the need to express emotions through verbal language and words. The difficulty of putting emotions into words is called alexithymia, which is a salient feature of the FEDs (particularly AN and BN), therefore for those patients art therapy could be particularly effective in combination with classic treatments (Diamond-Raab & Orrell-Valente, 2002; Dubois, 2010).

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MoP has been experienced in people with FEDs and some intriguing and interesting researches have been developed. Baddeley et al. conducted a program named "Sharing the Douglas" in partnership with the Montreal Museum of Fine Arts (MMFA) and the Department of Creative Arts Therapies at Concordia University. The program contained an interactive visit to the museum and an artistic creation workshop for adult patient with FEDs from the Douglas Institute's Eating Disorders Unit. The guiding principles of the program were: overcome isolation and develop a greater sense of belonging to the community; promote a situation that could facilitate the development of self and a positive body image; analyze the theme of the body image in art and link it to the pervasive need to adhere to a stereotyped image of beauty; interact with artistic objects to foster the culture of seeing and doing and for therapeutic purposes. The program was truly innovative for the training of museum educators and art therapists with particular importance given to relationship, communication, listening and the free creative expression of the participants. Authors concluded "For participants with eating disorders, simply being able to NOT think about their bodies for a few hours is a radical act." (Baddeley, Evans, Lajeunesse, & Legari, 2017). Participants to "Sharing the Douglas" from 2014 to 2016 took part in a research design. They received standardized therapies comprising psychotherapy, group therapy, psychoeducation. 78 (76 females, mean age 25.55 yrs) patients achieved 13 visits to MMFA over 6 weeks and data were collected from thematic analysis derived from a short qualitative questionnaire. Results highlighted four main themes: 1) the program was pleasing and enriching experience characterized by the possibility to shift from beliefs that usually inhabit the mind doing something different and changing settings; 2) art therapy as a promoter for self-expression of emotions, self-regulating and creativity through manipulating different materials; 3) Museum visit as an interesting opportunity for discovery and learning with a sense of new perspective and 4) appreciation of personal and professional qualities of the museum operators. Patients completed also questionnaire on eating preoccupation and urges, body satisfaction, mood and satisfaction with museum visits at the beginning at the end of the first visit to the museum. 37.5% and 48.6% of participants were very satisfied and mostly satisfied respectively; 54.2% would to take part in a same activity in the future. Between the two observation times, the participants reported a significant reduction in anxiety (Thaler et al., 2017).

In a psychodynamic perspective, art therapy can activate a process of attenuating some verbal defenses such as intellectualization and isolation with the aim of eliciting emotions and feelings in a more direct way. Furthermore, the possibility of manipulating an artistic material refers to the experience of giving shape to a chaotic and indefinite inner experience. Conscious and unconscious aspects emerge through artistic forms, colors and materials; moreover anger, sadness and distorted body image take shape and can be made explicit (Diamond-Raab & Orrell-Valente, 2002; Lusebrink, 1989; Makin, 2000).

Object relations psychoanalysis considers the development of the human mind to be derived from person's relationship with a world of objects and the emotional experiences gained in these relationships. The process of internalization of these objects and above all the relationship that the subject builds with them shapes the patterns and the emotional structure of the mental life of the individual (Froggett & Trustram, 2014). In this frame some concepts are important for the purposes of our theme, the concept of evocative object and that of transitional area.

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C. Bollas defined the evocative object, an object that initiates chains of associations, activates emotional responses and nourishes imaginative activity (Bollas, 2009). D. W. Winnicott introduced the concept of the transitional area, starting with the notation on the use that children make of the transitional object. The transitional area has great importance for the development of the individual because it allows the possibility to experience an intermediate state of the mind between the internal world and external reality. Cultural and creative activities, which are indispensable to human mental life, belong to this intermediate area. The author also pointed out the notion of holding and containing which are important aspects in the very first pre-verbal relationship between mother and child and which promote the possibility of symbolizing psychic events and experiencing a cohesive and lasting sense of self (Winnicott, 1958, 1965).

From a psychosocial perspective the museum engagement activates an "evocative" link with the museum objects, which becomes a significant and vital relationship that is established between subjective experience, the museum and society and culture in the broadest sense. The use of a museum objects determines not only an enrichment in terms of information or cognitive learning but also in the sense of participation in the construction of identity through the joining of them with memories, reminiscences and antecedents (Froggett & Trustram, 2014).

The museum environment allows the establishment of conditions of increased involvement, attention and symbolization. L. Frogget and M. Trustam, starting from the above assumptions of the object relations psychoanalysis, supported the thesis that the museum space or also called the object museum could be interpreted such as an intersubjective, symbolic and aesthetic "third" in which the dynamics of encounter, the connection with the cultural sphere and the aesthetic qualities are placed in a space somewhere between the imagination and the outside world. Furthermore, the object museum expresses the potential to contain emotions and alleviate the anxiety of visitors, provide adequate conditions of attention and symbolization and in universal terms to hold certain objects collectively in mind and hence to expand the symbolic capacity of a shared culture (Froggett & Trustram, 2014).

A study with 10 hospitalized anorectic patients consisting in weekly art therapy sessions throughout 4 years identified the main conflict during the artistic process and art product, they were: 1) verbal and/or emotional-behavioral resistance to art therapy and attraction to artistic materials and the creative artistic process; 2) intensive creation of an artistic object and the desire to destroy it; 3) the desire and need to be looked after and held and the verbal inability to directly express this desire and need; 4) the need to be dependent and in a relationship with others and the desire to be autonomous; 5) the physical development of female sexuality and identity and the rejection of these physical developments and identity; 6) the need for complete control and the feeling of lack of control. These conflicts resume some theoretical explanation of FEDs and might explain some therapeutic implications of art therapy because inner conflicts are externalized and concretized with the possibility of reducing their resonance and the forces that sustain them. Art and art therapy may symbolically replace food in the negotiation of the underlying causes of anorexia nervosa (Rehavia-Hanauer, 2003; Schaverien, 1994).

Conclusion

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In mental health the need of psychosocial interventions is well established and especially FEDs may represent a very important field of application of these interventions. In recent years a certain type of indication has turned towards social prescriptions and among these Arts on prescription and Museum on prescription have received great attention especially in the UK. This review summarizes the main experiences, implications and results of the programs that used art therapy and museum visits in patients with FEDs. From the evaluation of the data collected, two aspects emerge that need to be investigated. The first is represented by the evidence of the reduced number of projects in Italy or at least of the research designs aimed at disseminating the results. The second is related to the need to experiment these programs in children and adolescent patients with FEDs, in fact the age of onset of AN and BN is increasingly lowering and at the same time new forms of eating disorders emerge in earlier times that fall within the larger container represented by the ARFID. It is desirable that university centers, health services for the care of FEDs and museum directors, together with the allocation of funds, can establish agreements in order to implement these programs in our territory.

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Appendix

Table 1: NICE guidelines treatments for AN, BN and BED in adults, children and Adolescents

	Adults	Children and adolescents
AN	• Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)	• The anorexia-nervosa-focused family therapy for children and young people (FT-AN),

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	• The Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) • The specialist supportive clinical management (SSCM) • The eating-disorder-focused focal psychodynamic therapy (FPT)	• Cognitive behavioural therapy (CBT-ED) • The adolescent-focused psychotherapy for anorexia nervosa in children and young people (AFP-AN)
BN	• The eating-disorder-focused cognitive behavioural therapy (CBT-ED) • Bulimia-nervosa-focused guided self-help for adults	• The bulimia-nervosa-focused family therapy (FT-BN)
BED	• Group eating-disorder-focused cognitive behavioural therapy (CBT-ED), individual CBT-ED • Binge-eating-disorder-focused guided self-help for adults	

AN: Anorexia Nervosa; BN: Bulimia Nervosa, BED: Binge Eating Disorder