What do we mean by support?

A discourse analysis of practitioners’ talk about facilitating support groups for eating and body image issues

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Purpose

To examine the ways service providers define, construct, and understand their practices and approaches in facilitating support groups for adults living with eating and body image issues in community-based settings.

Theoretical frameworks

• Post-structuralist discourse analysis
• Critical feminist perspective
Discourse & ‘Eating Disorders’

- Discourses: structures of knowledge, claims and practices through which we understand, explain and decide things, with the assumption that there is no knowledge, truths, or reality outside discourse (Healy, 2000).

- Critical feminist perspective: ‘eating disorders’ 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).

- Psycho-medical treatment models often paradoxically reinforce the gendered discourses that constitute eating and body image issues in the first place (Hepworth, 1999; Gremillion, 2003).

- Poor treatment outcomes are frequently attributed to service users, yet treatment methods, clinical practices, and their underlying assumptions are often left unquestioned (Hepworth, 1999; Malson et al., 2011; Moulding, 2006).
• Does not aim to discover what practitioners actually do, but how they define and construct their understandings and practices through language.

• Not an evaluation of practices; not advocating doing away with psycho-medical interventions entirely.

• Deconstructing and analyzing stories is not about determining which stories are more ‘true’ or ‘correct’ than others, but it is about understanding “the constitutive or shaping effects of all stories,” while recognizing that “some stories sponsor a broader range of options for action in life than do others” (White, 2001, p. 21).

• Identifying, deconstructing and politicizing taken-for-granted knowledge, with the hope of opening up new possibilities in practice (Parker, 1992).

• Art-based data collection tool as a way to invite alternative knowledges that may contradict my assumptions (Leavy, 2008).
Community-based support groups

- Often offered at community-based agencies and schools.
- Often an alternative, more accessible option to institutional-based treatment and private therapy in terms of wait time and cost.
- Can be local sites through which dominant discourses are reinforced, as well as spaces outside of institutions where alternative approaches can be fostered.
Participants

• 6 white women, 1 South American immigrant woman

• Backgrounds: social work (SSW, MSW), expressive arts training, counselling psychology, nursing, health/behavioural sciences

• 4 acquaintances, 1 connected through snowball sampling, 2 connected through LinkedIn

• Interviews: 5 in-person, 1 phone, 1 Skype; 35 – 90 minutes in duration

• All facilitated support groups in Ontario, 1 also led groups in British Columbia

• Between 3 months to 22 years of experience in group facilitation

• All have facilitated groups in community-based agencies, 2 have led groups at universities
Interview questions

Art-based exercise: to express the kind of support you wish to facilitate and to talk about the image

1. Length of time facilitating support groups
2. Current approaches to facilitating support groups
3. What informed your approaches, i.e. theories/models, knowledge, experience, values, beliefs, what drew you to these theories/models over others
4. View on your work in community-based setting in relations to institution-based treatment
5. Approach to issues of difference, i.e. gender, race, sexuality
6. Story about about a time when your approach seemed helpful or unhelpful
7. Hopes for community-based support
Analysis

• Informed by the technical process described in a discourse analytic study by Woolhouse, Day, Rickett & Milnes (2011)
  • Group data according to topic
  • Identify themes within topic
  • Identify the ways each theme is constructed or talked about
• Identify the discourses that are at work in the different ways the themes are talked about guided by Parker (1992)
  • How subjects are positioned
  • What can or cannot be said (taken-for-granted truth claims)
  • Power relations that are reinforced
  • Subjects and discourses that are subjugated
Topics of discussions: What do we mean by support?

- Support as imparting knowledge
- Support as mobilizing others’ knowledge
- Support as facilitating connections
- Support as solutions to challenges of difference
- Support as an alternative and a bridge to treatment

- Analysis is substantiated by excerpts and concepts from the interview transcripts and literature, which cannot be fully presented here. This presentation contains only a small part of the findings and analysis, thus painting a very incomplete picture of the study. Please refer to the actual PRP if you’d like to learn more about the study.
Support as imparting knowledge

“So I think there’s a part that first came to mind is doing a new foundation, which is at the bottom [...] 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.”
### Themes and discourses

| Description of practices | The importance of implementing:  
| • A predetermined group format  
| • Meanings of safety in a group  
| • Rules to maintain safety  
| • ‘Psychoeducation’ regarding the psychological, familial and social issues understood to be related to eating/body image difficulties |
| How subjects are positioned | People living with ‘eating disorders’ are positioned as in need of:  
| • Protection through rules that delimit what can or cannot be said in a group  
| • Education regarding the appropriate management and expression of emotions  
| Dichotomy between practitioner and client, expert and in need, normal and pathological |
| Discourses that may have shaped these constructions and positioning | • Discourses of Psychology and psychiatry  
| • Discourse of Self (Guilfoyle, 2001) – emotional distress described as signs of individual pathology and cognitive deficiency.  
| • Discourses of AOP/social work/post-structuralism – eating/body image problems as phenomena that shift according to cultural contexts |
“What I had in mind was a [...] head of a drum [...] 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.”
## Themes and discourses

| Descriptions of practices | • Facilitators learning from group members – sense of uncertainty regarding the group process and outcomes, being flexible depending on client response and feedback  
• Encouraging clients to support, lead, and take responsibilities |
|---|---|
| How subjects are positioned | • Seems to challenge the position of the knowledgeable practitioner  
• Yet client leadership often delineated within the structures and rules already set out by the facilitators |
| Discourses that may have shaped these constructions and positioning | • AOP/activist social work discourse – Power sharing and client leadership practices (Healy, 2000)  
• Neoliberal discourse and organizational practices in the social service sector – client satisfaction, maintaining group attendance, validating program effectiveness and securing funding (Gibson, O’Donnell & Rideout, 2007) |
Support as facilitating connections

“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.”
## Themes and discourses

| Descriptions of practices | • Facilitating connections over shared experiences – isolation described as a ‘fact’ of ‘eating disorders’
• Disconnections attributed to interpersonal problems, lack of readiness for change, severe mental health issues that are not ‘eating disorders’
• Approaching problems with rules and education – ‘exclusion criteria’, avoid ‘dominating’ conversation, assertiveness skills |
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<td>How subjects are positioned</td>
<td>• Clients positioned as too irrational and unstable to be aware of others’ needs, hence the necessity of rules to ensure equal participation; yet they are also perceived as hyper-aware of others’ needs and unable to meet their own needs, hence the need to teach assertiveness skills.</td>
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| Discourses that may have shaped these constructions and positioning | • Psychology and psychiatry – Clinical narrative positions individuals with ‘eating disorders’ as lacking social skills and unable to meet their own needs (Choat, 2010).
• Conceals discourse of sanism (Linville et al., 2012).
• Onus on women to be more assertive but does not address sexist ideologies that devalue women’s voices.
• Biomedical discourse of ‘eating disorders’ shaped by racialized and classed norms – barriers to support for many (Gremillion, 2003). |
Support as solutions to challenges of difference

“And so these are all hands, arms, and um they are the different colours [...] just representing the diversity [...] I believe one can facilitate just about any group and bring out the connection in the group [...] you can pretty well put together any people [...] it’s how it’s facilitated. And creating an environment that’s respectful where everyone can be heard.”
## Themes and discourses

### Descriptions of practices
- Emphasizing similarity or sameness of experience of ‘eating disorders’ is constructed as a solution to mitigate the tension that may arise from differences
- Addressing and exploring differences in the group

### How subjects are positioned
- Essentializes individuals living with eating and body image issues as having the same set of characteristics.

### Discourses that may have shaped these constructions
- Challenges discourses of psychiatry and gender that feminize eating and body image issues by constructing these issues as relevant to both women and men.
- May also reinforce biomedical and psychiatric discourses – ‘eating disorders’ as a neutral entity that produces the same ‘symptoms’ in different people.
- Assumption that difference is something that needs to be overcome, thus possibly subjugating alternative knowledges and experiences, precluding an examination of the various social inequalities that give rise to eating/body image issues.
- Obscures the gendered discourses that constitute and are articulated through women’s eating and body image difficulties (Malson, 2009)
Support as an alternative and a bridge to treatment

“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 [...] 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?”
### Themes and discourses

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<th>Descriptions of practices</th>
<th>How subjects are discursively positioned</th>
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| • ‘Support’ is defined as ‘not treatment’.  
• Support groups described as preparation for ‘treatment’.  
• Collaborating with formal treatment approaches  
• Community-based support also described as being less rigid and therefore having greater capacity than institutional treatment to meet clients’ diverse needs. | • Within dominant psychiatric discourse, support group facilitators may be positioned as having less expertise than clinical practitioners – the operation of power that delimits the number of people who have access to and can speak certain truths (Guilfoyle, 2001).  
• Being position as having less expertise seems to have created space for practices that shift away or resist the authoritarian approach that characterize medical/psychiatric treatments.  
• Relationship of collaboration with shared beliefs – Where might clients find space to question practices? |
Implications for practice and research

- Historicizing the constructs of ‘eating disorders’ (Boler, 1999), and look for opportunities to include the specific histories and genealogical development of diagnoses such as ‘anorexia’ and ‘bulimia’ in our conversations.

- Raising questions about how each of us is inevitably implicated in discourses that oppress and subjugate.

- Raising questions about the extent to which specialized support groups can benefit people, as well as the groups’ potential to essentialize and exclude.

- Raising questions about the limitations of the group format rather than attributing problems that arise in groups to the problems of the individual.

- Raising questions about how we can co-create communities that foster an appreciation and desire for difference (Boler, 1999).
Limitations

• My role as sole researcher

• The voices of those living with eating and body image difficulties are largely left out.

• The term ‘eating and body image issues’ may conflate diverse practices, subjectivities and experiences related to food and the body.

• The scope of this study is limited to certain issues around gender, leaving out much of the discussions about race, class, age, sexuality, and gender expressions, which are also linked to eating/body image issues.
References


