“I Just Want to Melt Away”:
‘Treatment’ of Women with Eating Issues:
A Critical Feminist Informed View of
Art Therapy and the Exploration of an Alternative
Approach

by Claire Edwards

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Dedication

For my parents
Acknowledgements

Thanks and admiration to all the clients whom I have had the privilege to work with, and who have taught me so much, especially to Anne and Barb (not their real names) for participating in this study. Thanks also to my colleagues, past and present, for supporting my work, especially to Sandra Young for her input into this project. Thanks to the staff at Ipswich Women’s Health Centre, and to Isis, Centre for Women’s Action on Eating Issues. Thanks to supervisors Jill Westwood and Dr Adrian Carr for giving me valuable guidance, to Dr Andrea Gilroy for inspiration, and to my Masters of Arts (Honours) Art Therapy student peers for paving the way. Also huge thanks to my patient family, Simon, Sam and Josh, for tolerating the long gestation period this thesis required.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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(Signature)
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This thesis, which includes a dual case study, explores the clinical use of art therapy with women with eating issues from a feminist perspective. It provides a critique of the existing art therapy literature, and suggests alternative approaches which may be incorporated into an art therapy intervention, to increase its relevance to this client group. It demonstrates the need for flexibility and creativity on the part of the art therapist, particularly with regard to the provision of structure and containment. It offers an example of qualitative research methods which were easily incorporated into clinical practice, as a means to introducing clients’ voices into art therapy narratives as well as evaluating practice. These research methods are suggested for future art therapy research projects.

This study found that a short term feminist informed art therapy intervention was able to meet its goals of increasing clients’ self-awareness and insight into their eating issues. The use of art therapy was found to be one of the strategies which contributed to the success of this intervention. Other important aspects included: the adoption of a feminist model; the use of journalling; a flexible approach; a concern with what lay beneath the eating issue; and a focus on self-care and nurture.
Preface

The picture in Figure 1 is by “Bridget”, a young woman in a drug and alcohol rehabilitation centre, who had an eating issue as well as an alcohol problem. In this picture, entitled “Leave me Alone!!” she portrays her “inner critic”: a male who appears to be yelling angrily at her. His words are represented in four speech bubbles which command: “You can go without: have some control”; “That will put weight on”; “You big fat pig, how could you eat!”; “You’ll get fat, glutton!” He looks like a toddler having a temper tantrum, with his furrowed brows, red, angry eyes and mouth, and his scrunched-up posture, which makes him look as if he is jumping up and down in absolute fury. This character is dressed in black and white striped clothes, which remind me of stereotypical prison garb, or that of a burglar. He stands inside a yellow circle. Orange lines emanate from his scalp: it is not clear if they represent hair standing on end, or stress/energy lines.

Bridget herself is not in the picture, but she has drawn herself a thought bubble, which is saying “Leave me alone!!” The bubble emerges from the bottom right hand corner of the paper, so it is as if we are Bridget, looking at the person who has control of our thought and actions. Her cry is reminiscent of Crisp’s (1980) book sub-title: Let me be! This image fascinated me when I first saw it, as it seemed to illustrate a powerful cognitive experience. It was like looking inside the mind of someone with a serious eating issue. This image, created by Bridget some years before I embarked on this current study, is what prompted my interest in using art therapy to find new ways of working which would explore both cognitive and emotional aspects of eating issues.
Figure 1: “Leave me Alone!” By Bridget
Chapter One: Introduction

“I could not talk about being big” (Butler, 1983, p. 67).

1.1 Introduction

This thesis aims to examine current art therapy treatment for women with eating disorders/issues; to explore an alternative, feminist-informed approach to art therapy with these clients; and to describe and evaluate an art therapy intervention based on this latter approach.

In this chapter the purpose of this study will be outlined, and the term “eating issue” will be introduced and clarified. Three fundamental matters that are pertinent to this study will be raised, namely: - first, that the increasing incidence of serious eating disorders/issues in women and girls is a matter of major concern; second, that the ‘traditional’ art therapy approach, which is described in the current literature, needs to be evaluated and critiqued; and third, an alternative, feminist-informed art therapy approach will be suggested. Finally an intervention using this alternative approach will be outlined and described.

1.2 The incidence of eating disorders/issues

Eating disorders/issues are becoming more prevalent in Western countries and other developed nations (Malson, 1998, pp 3-5). Generally, individuals with eating issues are seen as challenging patients, who are difficult to treat (M. Wood, 1996, p. 19). Below a certain weight, the patient’s capacity for thought, insight and growth, both literal and metaphorical, may be severely compromised by her physical condition. Eating
disorders/issues are increasingly affecting younger children as well as large numbers of women and a rising number of men and boys (Jacob, 2001, p. 35).

For the purpose of this study, I have chosen to focus on women with eating disorders/issues, simply because they form the vast majority of the clinical population. In addition, I will suggest that there is a useful parallel to be drawn between the clinical population and the female population in general, in terms of body image, preoccupation with food, diet and weight, and the actual experience of body weight fluctuations (see for example Brown, 1993, pp. 53-68). These cultural factors are not currently applicable to males to the same degree.

The issue of gender differences will be developed further in the exploration of feminist therapy practice in chapter four of this thesis, where links will be made between the socio-cultural environments in Western countries in particular, and the incidence of eating disorders/issues.

1.3 The ‘traditional’ art therapy approach

This study includes an extensive literature survey in relation to art therapy and eating disorders. The ‘traditional’ psychoanalytic art therapy approach is characterised by a reliance on object relations theory. This has resulted in a particular narrow focus on the individual and her immediate family, and on the art therapist’s view of art therapy. The art therapy literature is considered with regard to common themes and recommendations, and is critiqued with regard to omissions and biases identified by the author.
1.4 An alternative approach

Following this critique of the existing art therapy literature, a number of alternative approaches is explored, informed by feminist therapy and clinical approaches not frequently considered in art therapy writing. A dual case study using art therapy, which implemented these alternative approaches, is documented and evaluated.

1.5 The term “eating issue” clarified

The term ‘eating issue’ will generally be used in this thesis to refer to ‘eating disorders’ such as anorexia nervosa, bulimia and compulsive eating. In choosing to use the generic and less medicalised term eating issue, I am aiming to make the following points.

Continuum of eating distress

The first argument for the use of the term eating issue is to emphasise the concept that eating distress exists on a continuum. Problems with body image, eating and food affect large numbers of the (female) population. Indeed, according to feminist theorists, the clinical population (those requiring treatment) represents the severe end of a continuum of eating preoccupation and/or distress amongst the majority of women in Western societies (Brown, 1993, pp. 53-68; McNulty, 1998, p. 15).
In addition, the use of a single term, ‘eating issue’, as opposed to clinical distinctions between, say, anorexia and bulimia, recognises the underlying similarities of these various conditions, rather than the differences (Brown, 1993, pp. 55-56). Brown (1993) suggests, moreover, that:

A framework which emphasises the similarities between women on a continuum of troubled eating and weight preoccupation allows for a feminist understanding and approach to working with women. (p. 56)

If we focus on the diagnostic differences between an anorexic woman and a compulsive eater, we may overlook the similarities. By focusing on the similarities, we may be more inclined to look at what lies beneath the eating behaviour, rather than the behaviour itself (Orbach, 1982, p. 16). Becky Thompson (1994), introducing her inter-racial, phenomenological study of 18 women with eating problems, takes this point even further when she argues that she avoids using the term “disorder” since:

For many women, bingeing, purging and dieting begin as creative coping mechanisms in highly “disordered” circumstances. (Thompson, 1994, p. 6)

Thompson (1994) highlights the negative use of the term disorder, and at the same time relocates the problem from the individual woman to her environment. She also transforms the problem behaviour from a symptom to a “creative” response to a disordered environment.

The continuum of eating distress is very useful concept which underpins much of the thinking in this thesis. It stresses the common elements of eating problems amongst women, particularly in terms of preoccupation with weight and body image, and the psychological effect this has upon the self. It suggests moreover that cultural influences are important factors in the development of the wide range of eating distress experienced by women in Western culture.
Non-medical framework

For simplicity, I have chosen to retain the word ‘treatment’ as a generic descriptor of what art therapists do with clients, despite a possible interpretation of this as a medical term. If we consider the verb ‘to treat’, then we understand that it refers to a wider context than the medical model alone. It is concerned with the way one group of people behave towards another, namely the way art therapists ‘treat’ clients with eating issues. This concern, which goes beyond the clinical intervention and involves ethical considerations as well, forms the basis of this thesis.

I use the term ‘eating issue’ to locate my interest in the exploration of alternative models of treatment, which are non-medical, and which rely on women defining their own terms, rather than having them assigned from the Diagnostic and Statistical Manual-IV (DSM-IV). This alternative terminology challenges the biomedical approach to eating problems. It is not intended to suggest that women are not extremely incapacitated and disadvantaged by their eating issues. The use of the term ‘disorder’, however, medicalises the eating problem and, of itself, may imply that medical intervention alone is helpful.

In this thesis I will be focusing more on the cognitive and emotional aspects of eating disorders rather than physiological aspects such as food intake and body weight. The term ‘eating issue’ denotes that an individual has ‘an issue’ with eating, which makes more explicit the cognitive and emotional aspect of the problem. This is not to deny a genetic or more biologically-based origin, nor that the various conditions should not be treated holistically, encompassing biological, cognitive and social elements in therapy. Using the term ‘eating issue’, however, suggests that women should be seen as individuals with complex behavioural, physiological and psychological problems, and who should be respectfully treated in a holistic manner.
In the interests of clarity however, I have included the following definitions according to DSM-IV, which is the commonly used medical reference for diagnosis, since other authors cited in the literature use these generally accepted terms. These definitions clearly include behavioural and cognitive factors, as well as biological features, in describing the various eating disorders.

Anorexia is defined in DSM-IV as:

1. A refusal to maintain body weight at or above a minimally normal weight for age and height (less than 85% of that expected).
2. An intense fear of gaining weight and becoming fat, even though underweight.
3. An undue influence of body shape or weight on self-image, or denial of the seriousness of the current low body weight.

Bulimia is defined in DSM-IV as:

Recurrent episodes of binge eating, which involves eating in a discrete period of time a larger amount of food than most people would during a similar period of time under similar conditions, and a sense of lack of control over that eating. Recurrent, inappropriate compensatory behaviours to prevent weight gain, such as self-induced vomiting and misuse of laxatives, diuretics and diet pills, occurring more than twice a week. The binge eating and inappropriate compensatory behaviours each occur at least twice a week over a three month period. An over concern with weight and body shape, affecting self-image. The disturbance does not only occur during episodes of anorexia nervosa. (Makin, 2000, p. 28)

Other eating issues referred to in the literature include compulsive binge-eating or overeating, which is defined as follows:

Genuinely large amounts of food are consumed at one time, leaving the person feeling guilty, uncomfortable and depressed. Sufferers do not subject themselves to extreme weight control measures, so Body Mass Index (BMI) is high. (Jacob, 2001, p. 40)
Jacob (2001) also identifies “compulsive dieting”, “athletica nervosa” (excessive exercising to control body size) and “eating disorders not otherwise specified” [such as night bingeing, and “orthorexia”, which refers to “an unhealthy preoccupation with healthy foods” (p. 43)] as variations on anorexia nervosa and bulimia nervosa.

Eating issues consist of a complex mix of factors including biological, social and behavioural elements. The term frequently describes a chronic condition, which takes many years to overcome completely. Anorexia in particular has been in focus, both in the clinical literature and the popular media, where to a certain extent it is viewed in both arenas as a fascinating but unsolved problem. Eating issues seem to represent something significant in Western popular culture, since they encompass issues of identity, consumption and embodiment in a global culture which minimizes individual identity, encourages excessive consumption, and is preoccupied with style over substance and (electronic) image over reality. As Mary-Jayne Rust (2000) asks:

If female fashion models, our role models for today’s young women, are so dangerously thin, and our ideal way of life is seen as going further in the direction we are already headed, perhaps it is our Western cultural notions of health and livelihood that need to be questioned. Is there not something very wrong indeed when we glorify women who are thin to the point of starvation? (p. 189)

This thesis will explore how art therapy may be of assistance in helping women with eating issues to address issues of identity, consumption and embodiment from within this complex and at times hostile environment.

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1 In addressing the issue of diagnosis, Ann McNulty (1998, p. 23) makes an interesting conjecture, that clinicians may be more comfortable writing about anorexia, which describes women’s deficit (not eating) rather than bulimia or compulsive eating, which name women’s desire (eating without restraint). This is certainly indicated in the sheer volume of writing about anorexia as opposed to the other less ‘intriguing’ eating ‘disorders’, both in the art therapy literature, in the clinical literature in general, and indeed in the popular media. “There is an irony in this”, McNulty writes, “given that a woman diagnosed as anorexic reduces food intake and body weight, becoming less and less substantial and taking up less and less space” (p. 12). It is as if, according to McNulty, “professionals appear drawn into the space, to fill it with their knowledge” (p. 12).

2 Duguid (2004) describes how “once unknown in South Africa, cases of anorexia among black women have soared since the end of apartheid” and that “…in cities, where Western culture has taken hold, black women, like white women, always want to be slimmer”. (p. 20)
This chapter has outlined the purpose of this study, and introduced some of the
terminology used. The following chapter, chapter two, will describe the approaches
commonly taken by art therapists in treating women with eating issues, in a survey of the
literature from 1980 to the present (2005). Subsequent chapters are as follows: chapter
three provides a critique of the existing art therapy literature. Chapter four introduces
some alternative non-art therapy approaches to treatment of eating issues, informed
largely by feminist therapy and other “new order” psychotherapies. Chapter five lays the
foundation of a feminist informed, art therapy methodology for the treatment of eating
issues. Chapter six describes the design and methodology for exploring feminist
informed art therapy practice in a specific community setting. Chapter seven gives a
narrative of the art therapy intervention that was implemented in this dual case study.
Chapter eight gives the results of the case study, and chapter nine discusses and evaluates
these results in relation to the issues identified in the art therapy literature. The final
chapter, ten, concludes this thesis with an overview of this study.
Chapter two: Literature review:
Art therapy with women with eating issues

It remains a challenge for the analytically oriented therapist to keep in mind at all times the social and cultural context, within which an individual’s (or group’s) abundant internal psychic material presents itself. (Levens, 1994b, p. 78)

2.1 Introduction

The previous chapter introduced the topic of art therapy’s treatment of women with eating issues, and indicated the overall purpose of this thesis. This chapter specifically refers to literature on art therapy and eating issues from 1980 to 2005.

Art therapists, mainly in Britain and the United States of America, have been writing about their treatment of women with eating issues for the past 25 years. The art therapy literature on this topic is surprisingly extensive. It does however have some limitations and blind spots, which will be explored further in chapter three. Subsequent chapters explore alternative approaches, in particular those informed by feminist therapy practice, and describe the implementation of an art therapy intervention informed by alternative approaches.

The art therapy literature review in this thesis, is organized in relation to a number of emergent and inter-related themes: 1) characteristics of women with eating issues and the therapeutic factors identified by art therapists; 2) descriptions of art work by women with eating issues; 3) the dilemmas posed for art therapists treating women with eating issues; 4) specific tasks given by art therapists for treating women with eating issues; and 5) beneficial qualities of specific art media, as claimed by art therapists.
Psychodynamic theory

Many art therapist writers cited in this review identify aspects of art therapy they consider to be beneficial for women with eating issues, and how underpinning psychodynamic theory supports this. Psychodynamic theory is seen by many art therapy theorists, particularly in Britain, as the dominant underlying theoretical framework which informs art therapy practice (Hogan, 1997b, p. 37; Karkou, 1999, p. 63). Psychodynamic theory, which originally derives from the psychoanalytic theory of Sigmund Freud (McDermott, Harris, & Gibbon, 2002, p. 313-314), suggests that patterns of problematic behaviour are established early in life, and involve the dynamic interplay between conscious and unconscious mental processes. Thus according to McDermott et al (2002):

Early psychodynamic theories that attempted to describe and explain anorexia nervosa emphasised psychologic conflicts concerning sexual fantasies, rejection of female sexuality, and interfamilial Oedipal struggles. Anorexia nervosa was perceived as a solution to these inner conflicts. Food refusal was believed to decrease anxiety, arrest sexual development, and organise family conflict around the physical aspects of the illness. (p. 314)

Object relations theory

Object relations theory, in particular the work of Donald Winnicott, (1980) is the psychodynamic approach most cited by art therapists as informing their practice (Karkou, 1999, p. 66). Object relations theory, which is a more recent development of Freudian psychoanalysis, (McDermott et al., 2002, p. 314) uses the developmental model of the early mother-child relationship as the basis for the therapeutic alliance.

Object relations theory proposes that the ‘potential space’ (Fuller, 1989, p. 9) created in psychotherapy (whether art therapy or other forms of psychotherapy) and the therapeutic alliance that this represents, form the basis for positive change to occur, through processes such as interpretation and transference. It is important to understand the object
relations approach as it dominates art therapists’ thinking about eating issues and their treatment of them.

2.2 Characteristics of women with eating issues and therapeutic factors identified by art therapists

The first section and most major section of this literature review identifies various characteristics of women with eating issues, as reported by art therapists and other clinicians. These features are considered with reference to the capacity of art therapy to be of benefit in that identified area, again as described by art therapists. Many of these characteristics centre on the core issues of self-identity and autonomy. The first section of this literature review explores these more individual, ‘micro’ features of anorexia and how art therapists have attempted to address these features. Subsequent sections will explore: socio-cultural issues; the benefits of group art therapy; descriptions of clients’ art work; dilemmas faced by art therapists; specified tasks and recommended media.

Autonomy of self and identity issues: Art therapy as self-actualisation

Many authors have described problems of identity and autonomy as being characteristic features of anorexia (e.g., Bruch, 1974, 1985; Fleming, 1989; Mitchell, 1980; Robertson, 1992; Welsby, 1998). This section explores how art therapists have approached these problems.

Drawing on the self-psychology theories of Kohut (1971) and Goodsitt (1985), art therapist Mari Fleming (1989, pp 279-304) argues that art therapy can help to “address deficits in the client’s structures and functions, related to needs for soothing, protection from stimulus overload, and mirroring” (p. 279). In her work with women with anorexia, Fleming utilises concepts of the “true” or “authentic” self to develop the theme of identity.
in women with eating issues. The concepts of the true (and false) self derive from Winnicott (Davis & Wallbridge, 1981, pp. 61-2), and have since been developed by Susie Orbach (1994, p. 169), who writes about the “false body” as an extension or elaboration of the false self.

In theoretical terms, the exploration and development of the true self, as opposed to the false self, is seen by Fleming (1989) as critical to the individual’s struggle to overcome anorexia. Hudgins (1989, p. 235) defines the false self as internalised “beliefs, structures and images of others”, whereas the true self is a more authentic and autonomous reflection of the individual personality, “capable of experiencing its own feelings” (Luepnitz, 1988, p. 188).

Many authors, as stated above, cite problems with self-determination as one of the key factors in the aetiology of anorexia. Mitchell (1980, p. 58) suggests the benefits of art therapy with women with anorexia include: the opportunity for self-expression, and for sharing with others, as well as assisting in the healthy process of introspection and gaining in self-awareness.

The decision to use materials in a particular way is seen literally as a statement of self-definition. Woodhead, Davis, Levens and Dolan (1997) state that this often involves women with eating disorders paying “great attention in their art to painting the boundary around their body” (p. 7). This suggests a lack of definition around their own boundaries, and therefore the need to strengthen them.

Similarly, Acharya Wood and Robinson (1995) state that art therapy:

…provides an arena in which the person can set about establishing and exploring a sense of personal autonomy and interpersonal boundaries. Like the pathological expression of these through the illness, the person is working through her body; the all-important difference is that art therapy is creative and non self-harming. (p. 254)
This theme, of the particular correlation between art therapy and autonomy, is developed further by Levens (1987; 1990; 1994a; 1994b) and Joy Schaverien (1987; 1989; 1994a; 1994b; 2000) in various publications, and is discussed in more detail later in this chapter.

Autonomy within the context of treatment

Matra Robertson (1992, p. 71), suggests that particularly in the context of orthodox medical treatment regimes, where the focus is often on weight gain and regaining physical health, art therapy can be beneficial in encouraging self-determination and self-expression in the anorexic client.

Paola Luzzatto (1994b, pp. 62-64), whose work is discussed in more detail in a later section, describes the “Self/World” image, frequently depicted as a “double trap”, which she notices occurring in her anorexic patients’ art work. This image seems to Luzzatto to be indicative of their particularly fragile sense of self in relation to a hostile environment. She argues (see Luzzatto, 1994b, p. 71) that this image of the double trap provides a framework within which positive change can occur. Like Robertson (1992), Luzzatto sees the self-in-context rather than in isolation.

Active participation: Art therapy as self-healing

An additional ‘therapeutic factor’, which was suggested in relation to orthodox treatment in the first section of this review, is that of “active participation” (Levens, 1987, p. 7). Indeed this is described by Murphy (1984) as “one of the most important aspects of art therapy with this client group” (p. 101). The main benefit claimed by many authors is that the woman starts to define herself by her actions instead of being a passive recipient of therapy (see for example, Bruch, 1974, p. 13; Jung, 1954a, p. 49; Woodhead et al.,
1997, p. 293). Bruch (1974) sees art therapy as being beneficial in the development of autonomy, since:

I have found artwork, and also dream reports, particularly useful, not so much for their unconscious symbolic content, but as aids in evoking a patient’s self-awareness, as illustrating his (sic) own patterns of experience, and of his way of expressing his concepts of his functioning and interactions with others. Art work and dreams serve to convince him that he does not function only under the influence of others, but that there are things which are truly his own, originating within him, expressing in his own imagery what goes on inside him. (pp. 345-346)

Similarly, Cooper and Milton (2003) suggest that:

…the more severe the difficulty patients have with interpersonal relationships, reality testing, and impulse control, the greater may be the relative advantages of action modalities (e.g. art therapy) over verbal ones. (p. 164)

The suggestion is that this active involvement in art therapy is what distinguishes it from, for example, verbal psychotherapy.

I have described how issues concerning the autonomous self and identity have been addressed in art therapy with women with eating issues. These include a consideration of the self, and the self-in-context. A number of the following themes could also be categorised as identity issues, but, for our purposes, are perhaps better considered separately as more specific aspects of self. The themes to which I refer are: - the psychodynamic process of splitting; body image distortion; and enmeshed relationship with the mother. These will now be examined in turn.

**Splitting and polarisation: Art therapy as an integrative process**

Several authors have identified the defensive psychodynamic process of ‘splitting’ as a feature of eating issues. Splitting is an element of Melanie Klein’s (1932) developmental object relations model, based on early infant-mother relationships. Splitting occurs
during the “paranoid schizoid position” described by Klein. It refers to the process whereby “babies ‘split off’ some of their internal feelings of discomfort and ‘badness’ and project them onto the environment in order to preserve their own sense of goodness” (Luepnitz, 1988, p. 187).

In a further elaboration of this theory, Klein (1932) hypothesizes that the infant thinks of its mother as consisting of two separate people, one who meets its needs (the ‘good’ mother) and one who does not (the ‘bad’ mother). In order to mature the infant needs to move to the next stage, namely the “depressive position”, in which it realizes that these two split off identities are actually the same person (the “good enough mother”) who meets its needs enough of the time. A feature of the depressive position is the development of healthy boundaries, in which as Winnicott (1980) puts it:

At this stage the child can say: ‘Here I am. What is inside me is me and what is outside me is not me’. The words inside and outside here refer simultaneously to the psyche and to the soma because I am assuming a satisfactory psychosomatic partnership, which of course is also a matter of healthy development. There is also the question of the mind, which has to be thought of separately, especially in so far as it becomes a phenomenon split off from the psyche-soma. (p. 153)

Describing her work with women at the more severe end of the eating disorder spectrum, in particular those with “borderline personality organisation”, and drawing on object relations theory, Levens (1994a) defines these individuals as having:

…great difficulty in sustaining any sense of stable self; they are liable to feel as if they are about to fall apart, and often turn to a range of destructive behaviours, partly in order to hold themselves together...This makes the world a very threatening place. (p. 160)

Levens (1994a) illustrates her point when she states that these women tend to “perceive their world quite simplistically in black and white” (p. 160). She suggests that this tendency towards splitting is due to a developmental disturbance in their capacity to relate to objects.
In other words, Levens (1994a) argues that these women embody Melanie Klein’s (1932) construct of the paranoid schizoid position; they do not have clear boundaries, and tend to see external objects, including other people, as either persecutory or perfect. In addition, they may have difficulty in discriminating what is inside and what is outside their bodies, and in recognising the difference between thoughts and actions. They have not, according to Levens (1994a, p. 160), developed the capacity for symbolic thought. This hypothesis will be explored more fully later in this chapter.

The process of splitting based on object relations theory can also occur in art therapy groups (see e.g. Cooper et al., 2003, p. 173). Fitzsimmons and Levy (1996, p. 287) describe the splitting which occurred in their short term art therapy group for young women with bulimia, with one facilitator being seen as “good”, and the other as “bad”. The group was seen by the authors to be beneficial “in that it helped group members to partly integrate the paranoid-schizoid split which served to maintain their bulimia” (p. 288).

*Mind-body split*

Mitchell (1980, p. 59) and Levens (1994a, p. 164) both describe an underlying mind-body split, characterised by denial of the body, which is at the core of their understanding of women with eating issues. Bruch (1978) states that her patients frequently “experience themselves and their bodies as separate entities, and it is the mind’s task to control the unruly and despised body” (p. 55).

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3 From a philosophical perspective this could be seen as an extension of Cartesian thought stemming from Western Enlightenment rationalism, which emphasised the supremacy of the mind over the body and asserted itself in Rene Descartes’ classic assertion “I think therefore I am”. 

20
This mind-body split in women with eating issues is exemplified by Levens (1994a, p. 164) as a battle between mind and body, where the individual over identifies with her mind and experiences her “body being a thing”. In other words the body, including the emotions, is not recognised as being part of the self; it is experienced as alien and unwanted, which needs to be defeated for the survival of the self. The self, for these women, is primarily located in the mind. Woodhead et al (1997) suggest that:

…the role of creative therapies must include encouraging the patient to become aware of the areas she cannot tolerate in herself, and to develop ways of being able to accept both her emotions and her body. (p. 296)

The implication is that by depicting these “unacceptable” parts of the self via art therapy, women are in some way able to integrate these parts into a more realistic and healthy whole self.

Another variation Bruch (1978) describes, is “feeling divided, as being a split person or two people” (p. 55). Interestingly, Bruch notes that the “secret but powerful split off part of the self seems always to be a male” (Ibid).

An additional “split” which has been mentioned in the previous section on autonomy, is that between the true and false self (Fleming, 1989, pp 279-304). Other splits or “oppositions” have also been noted in the art therapy literature. David Maclagan (1998) describes anorexia as a metaphysical struggle between oppositions such as spirit and matter, and life and death, noting how the anorexic “delights in taking things to extremes…there is no middle ground, no place for compromise, only either/or” (p. 79). In general, splitting phenomena emphasise tendencies towards extremes of various kinds and away from moderation.

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4 This theme of an internal battle has been characterized as a cognitive struggle between Negative Mind and Actual Mind (Claude-Pierre, 1997). It also recalls the analogy made by both Orbach (1986) and Greer (1999) between women with eating disorders and political hunger strikers who use their bodies as a medium of protest.
**Body image distortion: Art work as a mirror to the body**

The anorexic generally has an inaccurate, exaggerated view of her size. Marianne Crowl (1980) and June Murphy (1984, p. 98) both describe a distorted body image as one of the dominant features of anorexia.

As an aid to overcoming this phenomenon, Crowl (1980) suggests that body tracing as a group experience provides a useful tool, stating that “the comparison of their actual body size in relation to the body size of others is visually revealing” (p. 150).

Woodhead et al (1997, p. 295), as previously mentioned, also argue that working on the body outline, or boundary, in art therapy is beneficial in developing a whole sense of self for eating disordered patients. They suggest that disturbed body image is not just about body size, but that it also relates to issues of identity, powerlessness and lack of self-efficacy. Woodhead et al, like Levens (1994a), observe that “patients with eating disorders will frequently symbolise their difficulties through their feelings about their bodies” (Woodhead et al., 1997, p. 293).

This observation indicates to Woodhead et al (1997) that the concrete nature of art therapy, as previously mentioned, is particularly useful for these clients. The lack of a clear body boundary, for example, is a problem that can be addressed symbolically in art therapy. Issues of space and territory can become the focus of the artwork (Woodhead et al., 1997, p. 294).

In her work with individual clients, Rabin (2003, pp. 40-42) similarly uses body contour drawing, combining “phenomenal and non-phenomenal body image concepts” (p. 42) to create a life-sized self-image. Rabin sees this as perhaps the most significant of the directive tasks she uses, stating that:
Analysis of this work is a sensitive process that may stir up powerful feelings and require several sessions of intensive work with the therapist to explore the production. The task puts the client in touch with the reality of her physical size. For the client who suffers from an eating disorder...this is an especially potent process. The slow process of looking carefully at herself in order to complete the drawing forces the client to face each of her physical qualities. Having to make decisions as to the items to include, emphasise or change all play a role in helping the client acknowledge herself as a totality. The length, breadth, tactile quality, and, most of all, the client’s reality and aliveness are experienced nonverbally, over and over, and may help give credence to the idea that she exists in time and space. For these reasons the client may exhibit strong feelings when confronted with this image: for all its primitive execution, it holds a remarkable likeness to the individual portrayed. (p. 42)

These examples have shown how art therapy may be beneficial in addressing body image disturbance in women with eating issues, by providing a mirror to the body via the art work. The following section, still focusing on issues of autonomy, examines the family of origin of the client.

**Relationship with the mother: Art work as a container within the therapeutic relationship**

The relationship with her mother has frequently been identified as problematic for the woman with eating issues (e.g., Levens, 1987; Luepnitz, 1988; Murphy, 1984). The emphasis is usually on the mother being overinvolved or “enmeshed”, a term deriving from structural family therapy, (Minuchin, 1974, p. 54) with her daughter. The task then is for the woman with eating issues to separate from the mother and to develop an autonomous self.

In object relations terminology, the problem of enmeshment arises when the daughter has not experienced “good enough mothering” (Winnicott, 1980). Object relations theory, as previously discussed, provides art therapists with a model for the therapeutic relationship based on the mother-infant dyad. This is referred to using key terms such as “holding” (as in the baby being both physically and psychically held by the mother/carer) and
“containment” (the mother/carer’s capacity to reflect back the infant’s chaotic feelings in an acceptable form). If this has not been the infant’s experience, object relations theory suggests that the infant does not develop a sense of identity separate from the mother.

Various authors (e.g., Welsby, 1998) have argued that art therapy can provide clients with eating issues with the corrective experiences of holding and containment, which in turn may facilitate separation from the mother. This can occur through the particular “triangular relationship” (Schaverien, 2000) in art therapy as hypothesised in the following example from the art therapy literature.

In her case study of “Lucy”, a girl with anorexia and “damaged parents”, Carole Welsby (1998), describes an long term art therapy intervention which was both hospital and community based, and which managed to offer the continuity of working with the client for two and a quarter years. Welsby identifies the three main themes of her work with Lucy as: “The fusion with her mother; the development of the false self; and the struggle to separate from her mother” (Welsby, 1998, p. 35).

In Lucy’s case, she had been unable to separate from her mother, (who had a mental illness and was unable to care for Lucy adequately), “because of the guilt and anxiety that separating from a damaged mother causes” (pp. 35-6). According to Welsby (1998), the art work provided Lucy with an outlet that her mother could not:

It was as though Lucy had been waiting to find a container and now in the art therapy sessions she poured herself out in the painting. (p. 36)

Welsby (1998) suggests that Lucy did not become “fused” with her therapist, due to her own healthy resilience, and because:

…the natural transitional space which the triadic structure of art therapy provides, prevented such a fused relationship from forming. (p. 39)

In other words, Welsby (1998) argues that for patients who are unable to develop a transference relationship with the art therapist, which could mirror the original enmeshed relationship with the mother, the art work itself becomes the “container” for difficult
feelings. This hypothesis, also developed by Schaverien in various publications, (1987; 1989; 1992; 1994a; 1994b; 2000) suggests an additional unique quality art therapy may offer these clients.

As Welsby (1998) suggests, the art work may provide an alternative space for the client to experience a ‘non-enmeshed’ relationship. In another example, Norwegian art therapist Ase Minde (1993), conveys the subtle use of imagery in art therapy, with particular reference to the transference relationship, in the following vignette.

Minde (1993) describes the use of a carefully chosen image as a “holding” device for her client, a young woman with an eating disorder. She describes her work with the client, who depicted her struggle as an endlessly long road. Minde, realising this woman’s sense of desperation, sent her a postcard of a painting of a mother with a baby in her arms, and reminded her of their next session. The woman said, months later, “the card told me that you would be there to help me along the road” (Jennings et al., 1993, pp. 47-8). Minde used an image of a woman holding a child to convey her concern, whereas possibly a more direct expression may have been less welcome.

Levens (1994a) makes a similar point, about the need to meet the client at the appropriate level:

…it seems absolutely appropriate to meet patients functioning at this concrete stage of body experience at the right level. They may not yet be able to make use of the symbolic concept that they are cared about unless the care is demonstrated physically and literally, or they feel that their inner emptiness is connected to lack of care or love. (p. 169)

This would appear to suggest the need for therapy for these young women to be experienced as a form of nurture, which can be assisted by the “concrete” nature of the art therapy process, and where the triangulation of the art materials into the therapeutic alliance provides added space, distance and safety.
The provision of art materials as a metaphor for food and body contents, which again relates to the “concrete” nature of art therapy with this client group, will be discussed again in a later section of this chapter.

Control/perfectionism: Art therapy as mastery

Control has been identified as a key issue with women with eating disorders. Psychotherapist Marilyn Lawrence (1979) has coined the term the “control paradox” of anorexia nervosa. The paradox she refers to is the anorexic’s extreme control over food and her body on the one hand, and the sense of being “utterly out of control” (p. 93) in all other areas of her life.

This sense of physical control, based on self-denial, stems from the individual’s ability to control body weight and appetite to an extreme degree (Crisp, 1980, p. 16). This ability can lead to feelings of mastery and euphoria, which tend to reinforce the problematic (non-eating) behaviour. Thus, the concept of recovery often centres on a fear of loss of control. Murphy (1984, p. 101) highlights the anorexic’s fear of losing control as being central, and suggests that this fear may result in a refusal to participate in art therapy.

Lawrence (1979) makes the point that the psychotherapist needs to be comfortable with ambiguity and holding opposing points of view. She suggests that “the only viable therapeutic stance is one which can accept both sides of the paradox and hold them both without trying to force a resolution” (p. 100). Art therapy, Murphy (1984) argues, can, paradoxically provide the anorexic with a safe means of gaining control through mastery of the media, whilst at the same time helping her to “loosen some of (her)...established barriers” (p. 102) and thereby gain greater understanding of her defence mechanisms. Holly Matto (1997) seems to be making a similar point when she argues that for these clients:
…art can become a process of creating order out of chaos, allowing for the possibility of contained mess, chaos within the boundaries of the canvas, paper or other medium. (p. 348)

A particular form of the need to be in control is the pursuit of perfection. This has, again, been identified by many authors (e.g., Levens, 1987, p. 7) as a feature of anorexia. In his case study “P”, Maclagan (1998) describes this perfectionism as an anorexic aesthetic, which he calls the “negative sublime”:

In psychological terms, the negative sublime is a demanding image of impossible perfection whose influence on ordinary life is corrosive and potentially lethal…(it is) at once fascinating and terrible. (p. 81)

In their overview of the features of eating disorders, including anorexia, bulimia and disturbed body image in obesity, Woodhead et al (1997) argue that creative therapies can help overcome a need for perfectionism, as the emphasis is “never to do with ‘getting something right’ ” (p. 293).

Overcoming denial: Art work as a mirror to the eating issue

This section considers the psychodynamic construct of denial in the individual with eating issues, and how art therapy may assist to overcome this denial. In concrete terms, as stated in an earlier section, anorexia is the embodiment of self-denial. As Maclagan (1998) describes, the anorexic’s:

…needs for sensuous pleasure, emotional warmth or material comfort that are not met can be denied, and this renunciation can then seem like a sacrifice. (p. 86)  

Denial in the classic psychodynamic sense refers to the unconscious defence mechanism that blocks insight, namely the mistaken belief that nothing is wrong, often in the face of

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5 Maclagan (1998) is interested here in the spiritual aspect of anorexia, which is identified in Chapter three as an area which has not been explored by art therapists. In her recent history of the profession, Hogan (2001, pp. 313-315) has suggested that the spiritual aspect of art therapy, which is largely absent in the literature, has been bypassed in the professionalisation of art therapy.
much evidence to the contrary. The following characteristic statement is by “Alma”, a patient of Bruch’s:

I enjoy having this disease and I want it. I cannot convince myself that I am sick and that there is anything from which I have to recover. (Bruch, 1978, p. 2)

This denial, Mitchell (1980) argues, raises the central dilemma for those ‘treating’ women with anorexia, including art therapists, as “how to persuade a negative patient into doing what she is determined not to do” (p. 55). Even if we do not seek to persuade her to eat, we do wish to engage her in therapy, even though she may not believe she is unwell. This might tend to lead us to the question: - how might art therapy increase the individual’s capacity for developing insight and breaking through the barrier of denial? One implication is the notion that the use of art, as opposed to verbal therapy, may prove more “palatable” to the client. Words may be used defensively in therapy (Levens, 1987, p. 6), as in the following example.

Rabin (2003) illustrates this defensive use of words with the following vignette from individual art therapy:

Megan found it necessary to talk a great deal prior to the beginning each task, perhaps as a resistance. She was compulsive in telling the therapist everything she had thought about between sessions. She often made notes during the sessions so that she would not forget to tell the therapist her thoughts.

As Megan became more confident in doing the tasks and less fearful of what would emerge, she was able to defer her need to talk and get to the task at hand more easily. (p. 49)

Rabin (2003) compares clients’ statements about their art work with the art works themselves, and finds that after a period of time, the client is able to state that “his (sic) words didn’t match his picture” (p. 23).

In her longitudinal study of women with eating issues using a series of “phenomenal and non-phenomenal tasks”, Rabin (2003, p. 149) suggests that the focus on a single theme,
that of self-concept, through a variety of directive art therapy tasks, was in itself a factor in overcoming denial.

Writing about an unpublished Goldsmiths research project, Murphy (1984) suggests that the spontaneous imagery of the anorexic patients studied reflects both their inner world, and their behaviour and symptom patterns. This theme is a common thread through much of the literature, (e.g. Levens, 1987, p. 3) suggesting that artwork produced in art therapy can be seen as a “mirror” to the client’s condition.

Acharya et al (1995), describe the art of one woman with serious eating issues who attended an art therapy group in hospital. Although the woman did not improve, the art she produced was seen as providing insight into her condition (p. 251). Clearly, insight is not the same as recovery, but it may be considered, especially by those working from a psychodynamic perspective, as being one of the building blocks of recovery.

Murphy (1984) suggests that the mirroring function may in itself be therapeutic, since it can give valuable feedback and may produce insight. She predicts that:

…further work on this subject will reveal whether the expression of archetypal images...has any long term effect over time in terms of the therapeutic value of externalising some aspects of the self. (Murphy, 1984, p. 108)

The potential of art therapy, and the art work in particular, to provide a mirror to the eating issue has been discussed in this section. The following section takes this a step further in further developing the rationale for this potential benefit, using an object relations framework.
Concrete thinking: Art therapy as a bridge between inner and outer worlds

Bruch (1978) suggests that women with anorexia are characterised by “their concrete, childish style of thinking” (p. 70). This concept has been taken up by several art therapists and used as the platform for their theoretical approach. Levens (1987, p.3) argues that the individual with eating disorders is “unable to use psychological metaphors”, which leads her to use her body to express herself. Art therapy, Levens suggests, gives patients a safer, but still concrete, means of communication. In the introduction to her edited book on arts therapies and eating issues, Dokter (1994) argues that an object relations framework provides “a possible explanation for the suitability of arts therapies for these particular clients” (pp. 18-19). As previously noted, the theoretical, object relations foundation for this view, is that the woman with serious eating issues is in a regressed state, namely the “paranoid-schizoid position”, thinks only in black and white, and unable to use metaphors (Levens, 1987, 1994a).

If one accepts the premise that women with eating issues think concretely, one may argue firstly that this is demonstrated through the mirroring process mentioned in the previous section. The art work, in other words, provides a mirror, or lens, through which the woman may express and hopefully understand her illness. Parallels between the art-making process and specific features of her patients’ eating behaviours are apparent; for example, when Levens (1987) comments on the difference she perceives in style between anorexics, who frequently use ‘minimalist’, invisible/hidden, or idealised forms, and bulimics, who may spill over the boundary of the paper (p. 3).

Levens (1987) argues that art materials may literally be equated with bodily contents (or feelings) which need to be “got out”, as in the ‘Vomit Picture’ by her client Sandra. She suggests that for change to occur, however, the patient requires insight into her process, to move beyond “acting out” and “to use it constructively rather than perpetuating the use of a defensive action” (p. 3).
In a later work, Levens (1990) expands on this theme when she describes her work with women with eating issues and borderline personality disorder. Again, she cites the symbolic function of the art-work produced in art therapy as forming “a bridge between therapist and patient” (p. 280) as well as between “inner and outer reality” (p. 280). She draws a parallel with Winnicott’s (1953) concept of the transitional object\(^6\), arguing that eating disordered patients:

…retain the use of their bodies as transitional objects, which creates more difficulties for them, in that they have to struggle to keep their bodies utterly under control. (Levens, 1990, p. 280)

In another case example, Levens (1994b) describes her client ‘Lee’, as symbolically attacking herself through her art work, which she sees as a similar (although less harmful) process to self-mutilation (p. 89).

Levens (1994a) takes this concept of concrete thinking further in her chapter on art therapy and psychodrama with women with eating disorders, when she hypothesises about the benefits of using art therapy (and other experiential therapies) with these patients, arguing that these modalities:

…are uniquely able to work within the world of concrete objects and, by doing so, meet the patients in a way which feels genuine and authentic in order to facilitate their emotional growth. (p. 161)

In other words, Levens (1994a) argues that art therapy can assist eating disordered patients by providing them with an alternative means of negotiating the transitional space between self and others. The functional way art therapy does this is by enabling concrete expression as a prior step to symbolic thinking (p. 175).

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\(^6\) Winnicott (1953) describes the transitional object as a symbolic object that represents the transitional space that is “me and not-me”, with the child’s teddy bear being a classic example of this.
Woodhead et al. (1997) make a similar point. They describe the parallel between a symbolic “binge” with art materials and an actual binge episode, stating that this represents “potentially a far more useful binge that the type that leaves them feeling disgusted, guilty and ashamed” (p. 294). Exploration of the imagery, moreover, may help bulimic women to “explore the feelings behind the need to binge” (Ibid).

In a case example, American art therapist Darcy Lubbers (1991) demonstrates how art therapy can be used to redirect destructive acting out processes. A bulimic patient, ‘Sandy’, was about to burn her art work, but was redirected by the therapist into making a symbolic image “which would help her to regain self-composure and control over her impulses” to purge (Lubbers, 1991, p. 71). The paradoxical role of the art image as a holding device, and at the same time as a cathartic release, is exemplified by this description of Sandy’s art making process:

Sandy came to the session directly after lunch. She declared that she had a strong desire to act out by ‘purging’ her lunch, but had so far resisted and had chosen to come to the art therapy session instead. She then asked for the box of magazine pictures and…involved herself in creating the symbolic “binge-purge” collage. Once again she experienced a catharsis due to the emotional purging afforded by the art process, along with the healing aspect of sharing her pain with the therapist. Sandy revealed that she also felt a heightened sense of personal effectiveness because of the healthy and creative way she had found to resolve her immediate self-destructive impulses. (Lubbers, 1991, pp. 72-73)

Analytically oriented British art therapist Joy Schaverien (1994a) gives a mainly theoretical account of the potential benefits of art therapy and eating issues. Schaverien describes the condition of anorexia in a general sense:

The anorexic uses food to mediate between herself and the world. The attachment to, or interest in, food is obsessional...Its presence in the body is desired but also experienced as intrusive and disgusting...Terrified of loss of control and so fragmentation the anorexic is frozen on the borderline between life and death or control and madness. (Schaverien, 1994a, p. 51)

Schaverien (1994a) reiterates the connection made by Levens (1987; 1990; 1994a; 1994b), that the art work in art therapy can symbolically replace the use of food and the
body in anorexia. She does this by coining the term “transactional object” (Schaverien, 1994a, p. 46) to describe the artwork and its concrete role in mediating between the patient’s inner and external worlds.

Eating issues have at their core the fundamental conflict between life and death, self-worth and self-annihilation, as expressed through the dilemma of food, and how to take this life-enhancing matter safely into our body without risking loss of autonomy or body boundaries. The literature thus far suggests that the potential of art to contain and express these opposing impulses and needs gives us further insight into the effectiveness of art therapy with eating issues.

This part of the literature review has considered how art therapy may assist women with eating issues by enabling them to work through their psychological processes through the use of art as a concrete metaphor, which is a significant claim made for the benefits of art therapy for this client group.

The features reviewed thus far have been concerned with individual therapeutic aspects of art therapy with women with eating issues, which centre on the development of the autonomous self. The following section examines socio-cultural factors which impact on art therapy treatment, which then leads to the consideration of the benefits of group art therapy.

*Social and cultural factors: Art therapy in context*

As Rust (2000) has argued, “few writers or therapists have examined the complexities of the links between eating problems and the wider social context in which we live” (p. 189). Cultural factors are rarely mentioned briefly in the art therapy literature, as is demonstrated by the following examples.
Probably the first writer on the subject of art therapy with women with eating issues, psychiatrist and psychotherapist Hilde Bruch (1974; 1978), identified Western social and cultural attitudes towards the body, which strongly equate beauty and thinness, as being a potential source of the anorexic’s drive to starve herself in the pursuit of self-hood (see Bruch, 1978, p. viii).

In one of the first published articles written specifically on the subject, which describes a case study using art therapy with an anorexic woman, art therapist Diane Mitchell (1980) makes the connection between the individual woman and social pressures to be thin, stating that sufferers from anorexia:

…represent a pathetic illustration of the confused attitudes induced by society idolising certain body images for all of us. (p. 57)

Art therapist Mary Levens (1994b), one of the most prolific writers in this area, in her case study of a woman she calls “Lee”, steps outside her psychoanalytic frame and examines the wider socio-cultural arena which surrounds Lee and her self-destructive behaviours. She makes connections between Lee’s ‘pathology’, and women’s negative experiences of their bodies as a cultural norm:

Women are shamed into examining their bodies for excess hair, cellulite, stretch marks, sagging breasts and much more. The body is felt to be the guilty party. It causes men to lose control, it forces an awareness of dependency needs and creates hunger, it longs to be held when there is no one there and it can be blamed for feelings of worthlessness. (p. 90)

Levens (1994b) highlights the difficulties of bringing together sociological and psychodynamic frameworks, by stating that:

It remains a challenge for the analytically oriented therapist to keep in mind at all times the social and cultural context, within which an individual’s (or group’s) abundant internal psychic material presents itself. (p. 78)

Levens (1994b) clearly has put her finger on the very real dilemma art therapists (particularly those who are “analytically oriented”, perhaps) and other clinicians struggle
with, when they work with these clients, namely the need to consider both the client’s inner world and her external reality. She concedes that culture cannot be left outside the therapy room, and suggests, moreover, that what is true for the client is also true for the therapist:

All therapists are not only responding to their client’s personal communications, but bring to the therapeutic relationship their own cultural history, which interacts with that of their client. (p.78)

The following examples from the clinical literature feature comparisons between Western society and other cultures in their exploration of eating issues. Understanding anorexia primarily as the manifestation of a developmental crisis which occurs in adolescence, psychiatrist A.H. Crisp (1980, pp. 6-7) is interested in the culture that surrounds the illness. He contrasts the rituals that surround the onset of puberty within traditional cultures, with the lack of such rituals in our own (and other Western cultures), where anorexia is prevalent. If the primary tasks of adolescence are the development of both individual and social identity, Crisp seems to be suggesting that anorexia can be read as a critique of our culture, which does not provide adolescents with the supportive rituals they need to become healthy adults.

Using the logic that looking at other cultures may indeed shed more light on our own, Diane Waller (1994), has noted the social expectations and eating behaviours in the Balkans, in particular the former Yugoslavia and Bulgaria. She describes for example how food is used in these cultures as a mark of hospitality, especially towards strangers, and in which food refusal would have very negative social implications. Waller recalls this experience when she encounters women with eating issues in a clinical setting, and

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7 Crisp (1980) writes that:

...in many tribal cultures in the American sub-continent, Africa and Asia, the menarche was taken as the specific indicant of female puberty. It led to both immediate ritual and also the establishment of new customs and sometimes also taboos for the individual concerned thereafter...(puberty) is associated with immediate rituals often involving isolation, abstinence from eating in the female, and by the requirement that the adolescent conduct herself or himself in ways consonant with the tribe’s customs concerning adolescence. If such rules are flouted then punishment or banishment may follow. (pp. 6-7)
empathises with their negative reactions to clinical feeding regimes (p. 79). Waller suggests perhaps that the Balkans can be seen as a kind of “mirror image” of our own society, as in the following:

In societies in which food is powerful, either because there is too much of it or too little of it, and where a family’s identity and a woman’s role is closely bound up with it, it is not surprising that it can acquire a negative as well as a positive significance. (p. 81)

Rosal, Turner-Schikler and Yurt (1998) describe an art and nutrition therapy group for mainly African American “obese teens”, in which both gender and racial factors are studied. In their comparison of the race and gender of group members against the Rosenberg Self Esteem Scale (Rosenberg, 1979), the authors found that of all the individuals studied, young white girls “have the most difficulties with positive self-perception” (Rosal et al., 1998, p. 131). It is interesting that the dominant Western culture is identified as problematic almost accidentally, via a study into a group consisting of mainly black young people.

Art therapist Mury Rabin (2003) writes about the relationship between body image and culture, and its impact on eating issues, arguing that “little attention has been given to diagnosis and treatment of these addictive symptoms in males” (p. 20). She goes on to state that “both men and women are confused about the messages received from a culture that is in transition from one era to another” (p. 21).

I have briefly reviewed examples in the art therapy literature which consider the relationship between clients with eating issues and their cultural context. I have described Bruch (1974) and Crisp’s (1980) early assertions that culture plays a part in the aetiology of eating issues. Whilst not being art therapists, both authors have contributed significantly to the literature and have highlighted the role of art therapy in advance of art therapists’ later contributions. This is followed by material by Levens (1994b), Waller (1994), Rosal et al (1998) and more recently, Rabin (2003). Clearly some of the art therapy literature addresses cultural issues, albeit somewhat briefly, or tangentially.
Generally speaking, there has been little in-depth analysis of the interplay between cultural and intrapsychic processes related to women with eating issues in the art therapy literature. I will return to consider these issues in more depth in chapter five of this study. This will include the art therapists who have written about these issues in greater depth, using a feminist perspective, most notably Mary-Jayne Rust (1987; 1992; 1994), and Anne-Marie Norman (with Jill Ball) (1996). This completes the section reviewing cultural issues and art therapy.

**Benefits of art therapy groups: Art therapy as a social experience**

Not much discussion has been noted in the literature about the relative benefits of individual or group work with this client group. Where a preference is stated, it is usually for group work, [or this is seen as a progression from individual work (see e.g. Murphy, 1984)]. Schaverien (1987; 1989; 1994a; 1994b; 2000) is one of the few writers to prefer individual work (Makin, 2000).

Some authors (e.g. D. Waller, 1993) have described the particular benefits, or “curative factors” of art therapy groups, for women with eating issues. Andrea Gilroy (1995) has identified “an absence of research on experiential art therapy groups” (p. 67). Instead, she characterises the literature on art therapy groups as being descriptive of clinical work, “addressing issues such as structures and boundaries and the appropriateness of differing approaches for varying client populations” (Ibid).
Psychotherapy groups

As Gilroy (1995) has suggested, we may therefore benefit from a consideration of “therapeutic factors” in verbal psychotherapy groups which have been far more extensively researched (see for example, Bloch & Crouch, 1985) than art therapy groups. In order to research the use of long term outpatient psychotherapy groups, for example, Irvin Yalom (1985) and a group of colleagues identified and ranked 12 therapeutic factors, which they gleaned from the literature, using a “Q-sort”, which asks patients to rank various statements based upon the 12 factors (Marcovitz & Smith, 1983, pp. 22-23; Yalom, 1985, p. 71-80). The 12 factors were ranked as follows.

1. Interpersonal input
2. Catharsis
3. Group cohesiveness
4. Self-understanding
5. Interpersonal output
6. Existential awareness
7. Universality
8. Installation of hope
9. Altruism
10. Family re-enactment
11. Guidance
12. Identification (Yalom, 1985, p. 79)

Other authors (e.g. Marcovitz et al., 1983; Maxmen, 1973) have researched psychotherapy groups and produced similar results, with some variations (Marcovitz & Smith, 1983).

Art therapy groups: Therapeutic factors

I will now describe some of the benefits of art therapy group work with this population, as identified by the literature. I will firstly describe two examples which outline
therapeutic factors in specific art therapy models, before giving some case examples of art therapy groups with women with eating issues.

Diane Waller (1993) identifies nine factors from art therapy groups, which are somewhat reminiscent of Yalom’s (1985) list, and which are specific to her preferred model of “group interactive art therapy”. Like Yalom’s, Waller’s factors are not specifically intended to refer to eating issues, but to group interactive art therapy groups in general. Waller’s therapeutic factors are as follows:

- we have fewer established defence patterns when using art (compared to verbal psychotherapy groups)
- art offers an alternative means of expression
- “free association” on paper can lead to catharsis
- the art objects are full of symbolic meaning
- the artwork aids understanding
- it provides another avenue for the transference
- it is a focus for projection; it is a focus for interaction
- it can be less threatening than a verbal group
- there is an element of play
- the art work is a container for what has occurred in the group
- use of art can intensify the process
- the intrinsic value of creative activity (pp. 37-39)

It is noticeable that many of the factors Waller (1993) describes have previously been mentioned in the preceding section. In other words these factors are not necessarily specific to group art therapy. Waller defines her model of group interactive art therapy as being derived from a synthesis of “concepts from group analysis, interactive (or interpersonal) group psychotherapy, systems theory and art therapy” (p. 3). The focus is on the group as a whole, and the dynamics between members, rather than on individual content, thus:

…the model…involves awareness of the group as a “system” and willingness to use the social and cultural context of the group and its images as material for the group. As in verbal group therapy, the conductor avoids focusing on the
individual, or on the overt “content” of the session, but encourages the members to interact, being aware of the symbolic, metaphoric messages arising both from the image and the relationships among the members themselves. (D. Waller, 1993, pp. 40-41)

Waller (1993) acknowledges that there are both advantages and disadvantages of using art materials in a therapy group. She claims however, that “the making of images facilitates interaction among members and the therapist and stimulates the creativity of the participants” (p. 37).

Ball and Norman (1996) have described a feminist approach to art therapy groups with this client group. Their work has been evaluated by an independent consultant who found that the clients identified certain key benefits they had gained from the groups – not specifically the art therapy group, but all the groups offered by the service. These benefits included:

- Being able to talk to people with similar problems;
- Experiencing friendship, empathy, closeness and understanding;
- No longer feeling isolated, alienated or freakish;
- A realisation that other ‘normal’ looking people had problems too;
- Enjoying the informal atmosphere. (Ball et al., 1996, p. 57)

These benefits correlate closely with Yalom’s (1985) curative factors, in particular “universality”, in addition to meeting needs for support and socialising. These factors are supported by Liebmann (2004) who found in her MA research that when she:

…asked all the (art) therapists what purposes their groups had…the answers seemed to fall into two clusters: personal and social”. (p. 13)

Ball and Norman’s (1996) work will be revisited in chapter five in relation to utilising a feminist framework for art therapy.

The existing research into therapeutic factors in group psychotherapy, by various authors previously cited, and into art therapy groups by Gilroy (1995), Waller and Marian Liebmann (2004) will be revisited in chapter six, in relation to the methodology adopted.
Art therapy groups: Case examples

Waller (1993) gives an example of her “group interactive art therapy” approach in a description of a group of women with eating issues. The group interactive art therapy approach is one in which themes emerge spontaneously through the group process, rather than being suggested by the group conductor. This “somewhat fragmented” group of seven women with eating disorders, “was characterised by angry, envious feelings towards the therapist alternating with compliant, timid behaviour” (p. 130). This emergence of a common theme in the imagery of group members, which is not suggested by the facilitator, is referred to as “resonance” (p. 15). Waller (1993) argues that these women were able to use art imagery to express their unacknowledged anger, suggesting that this approach may indeed assist women with eating disorders in the cathartic expression of strong emotions.

Participation in group art therapy, according to Murphy (1984, p. 102), enables diversification of social relationships, which may often have been limited to the family prior to treatment. In addition, Fitzsimmons and Levy (1996) state that in their group for young women with bulimia, “the members could recognise they were not alone in their condition” (p. 288).

Woodhead et al (1997, p. 295) discuss the particular benefits of group art therapy which brings together bulimics and anorexics, where their different modes of functioning may be symbolically played out, over issues such as passivity, compliance and assertion.
Morenoff and Sobol (1989, p. 147) give the rationale for preferring group work above individual work for these clients as a way of slowing down the process, and providing mutual support and feedback. Their groups, which combine art therapy and verbal psychotherapy, are open-ended, and include women at very different stages in their recovery. Tasks are chosen which could be applied to the different stages of therapy. Morenoff and Sobel suggest, for the same reason perhaps, that a range of art media is offered, including wet and dry media.

Fitzsimmons and Levy (1996) describe a ten week group for young people with bulimia. The counter transference is alluded to in the description of the “two depressed leaders sunk in sadness” as a result of the “two participants losing weight in a competitive bid as to who could be the most bulimic” (p. 288). However there is a realisation that at least the issue of competitiveness was being addressed in the group, which was a breakthrough for these women (Ibid).

Fitzsimmons and Levy (1996) suggest that it was unhelpful having a group composed specifically of young women with bulimia, as opposed to a more heterogeneous group of young people. The authors based this statement on the fact that only two out of ten referrals attended the group. However it is not clear what the reasons for the non-attendance of the group were, as this is not explored in their article. Despite the low attendance, as already noted, the authors claim that the participants benefited from realising they were not alone (p. 288).

Rust (1987; 1992; 1994) has written about art therapy groups with women who are compulsive eaters as well as the more clinically based eating “disorders”. Her approach includes a feminist framework and is discussed more fully in chapter four of this thesis.

Johnson and Parkinson (1999) outline structural issues in their description of a psychoanalytically based art therapy group for women with eating issues. They discuss
the tension between the group coming together for discussion, and the group separating for art-making, which they argue is a unique aspect of art therapy groups. In addition, they claim that those who are unable to “recognize the unconscious communications in their work, are able to relate to the communications of others” (p. 90).

The time limited nature of art therapy group interventions is also raised by Johnson et al (1999). They discuss their view that the group is not “all or nothing” but is “something in-between” The response to the group is also understood by Johnson et al as a parallel to the response to food:

Typically, patients suffering from bulimia have found it difficult to absorb regularly what the group has to offer. This may mirror their use of food. It is as if they can take something in form one week only to spit it out and get rid of it by not attending the following week. (p. 94)

Group boundaries may also be challenged by coming late, as an expression of anger which cannot be directly expressed (Johnson et al., 1999, p. 94).

Johnson et al (1999) also outline the benefits of the “mirror phenomena” described by Behr and Hearst (1973) in which individuals may recognise aspects of themselves in others, and suggest this may also occur through the art work (Johnson et al., 1999, p. 90). Johnson et al (1999) refer to the group analytic work of Foulkes (1964), who has described group psychotherapy, aptly in relation to this client group, as:

…the raising of communication from the inarticulate and autistic expression by the symptom to the recognition of underlying conflict and problems which can be conveyed, shared and discussed in everyday language. (pp. 68-69)

Johnson et al (1999) seem to suggest that the art work has a similar or auxiliary role to that of language, as another means of both identifying conflicts and sharing them with others. Socialisation is cited by Johnson et al (1999, p. 91) as another benefit of therapy groups, a point that was previously made by various authors (Ball et al., 1996; Liebmann, 2004; Murphy, 1984).
Johnson et al (1999, p. 92) also make note of the “materiality” of art materials and their parallel with food. This point has been raised by Levens (1987) and Schaverien (1987; 1989; 1994b) but Johnson et al (1999, p. 92) make a further claim regarding the benefits of the “public” nature of the group, contrasting this with the usual secrecy surrounding bingeing and vomiting behaviours. The art work is seen by Johnson et al (1999, p. 94) as a mirror to the eating issue. The group process, according to Johnson et al, moves towards greater self- and social awareness:

…from members seeing their own and each other’s feelings expressed in the art work, towards recognising and experiencing the feelings in their own bodies and in the experience between themselves. (Johnson et al., 1999, p. 96)

Johnson et al argue that the group “is reflective of the family environment” (Johnson et al., 1999, p. 96), echoing Yalom’s (1985, p. 79) concept of “family re-enactment” which he identified as a therapeutic factor in groups.

Makin (2000) argues that group art therapy “tends to be the preferred model of treatment in in-patient settings, since it can work on several different levels at the same time” (p. 40). In other words, Makin suggests, patients are able to work fairly autonomously on their art, whilst engaging in verbal interaction within the group. Other benefits of group-work, according to Makin, include communication and social relationships, which can facilitate the sharing of strong feelings and experiences.

This part of the literature review has explored the particular benefits of art therapy groups for women with eating issues. What follows now are some of the descriptions of the art work made by these clients, as portrayed by the art therapists involved in their treatment, and some of the interpretations made by the art therapists of their clients’ art work.
Descriptions of art work by women with eating issues

This section notes some of the features art therapists have identified in the artwork of women with eating disorders, and the interpretations they have made of these features. A strong parallel is often identified between the art work and the client’s condition, as discussed in a previous section, which discussed the artwork as a mirror to the eating issue.

This parallel identified in the art work is related to the concept of the “materiality” of art materials, or images and the parallel with food, mentioned by various authors (Cooper et al., 2003; Johnson et al., 1999; Levens, 1987; Schaverien, 1994a). Thus the art work of anorexics is commonly portrayed as in the following description by Johnson et al (1999, p. 90) of a drawing by “a very thin patient” as “a faint pencil line of a figure who is hardly visible”. Similarly, they describe a bulimic woman as “extravagant” with paint, who threw her paintings in the bin and left the taps running whilst cleaning up her space:

Both therapists felt they were witnessing the ritualistic cleaning up of a bathroom after she had binged and vomited. Unconsciously she was bringing her shameful secret into the space of the group. (p. 92)

This focus on the materiality of art therapy, which suggests parallels between the art work and the symptom, and as a corollary, between the art-making process and the client’s relationship with food, provides much of the rationale for using art therapy with this population.

In a further example, Mitchell (1980) describes the ‘typical’ anorexic drawings in the early stages of therapy as being:

…rather well-structured, “pleasing” pictures (for example, flowers, cute animals, happy people)…this can represent a denial that anything is wrong, that her life is as she wants it to be. (p. 60)
June Murphy (1984) refers to a research project set up at Goldsmiths’ College in 1981 to “investigate the effectiveness of art/psychotherapy as a treatment for sufferers of eating disorders such as anorexia nervosa and obesity” (p. 103). Murphy does not evaluate the effectiveness of the project, however she does offer the following observations.

The research conducted at Goldsmiths’ identified particular recurrent themes through examining the spontaneous artwork of anorexic patients. This included avoidance of the human figure, idealised human figures, and images of social isolation. Further themes emerged in individual sessions which seemed to be linked to stages of therapy, such as:

- Concise extrinsic patterns, for example, whirlpools and bottomless pits;
- Animals, usually dogs and horses;
- Flowers and plants, cacti and thorns; and
- Landscapes and gardens. (Murphy, 1984, p. 104)

Murphy (1984) states that progress often followed the pattern as shown above, but at times the patients would return from the more expressive stages to the earlier concise patterns, which was linked to a retreat into defensive and ritualistic behaviour patterns. She argues that it is impossible to determine whether such images:

- …reflect the various stages of the anorexic condition in terms of resolving some inner conflicts, or whether the expression of these images actually brings about or promotes therapeutic change. (p. 104)

Although Murphy (1984) believes that interpretation of the images is matter for speculation, due to lack of articulation by the anorexic patient, she suggests that various stages can be identified. The intricate patterns, she argues, are linked to defensive behaviours, as stated above. The dog and horse images may be linked to the anorexic’s urge for exercise, according to Murphy. She suggests that the plant forms may be symbolic “self-portraits”, which may therefore demonstrate “some progress towards self-reflection” (pp. 105-106). The gardens and landscapes, which extend the plant theme to include an external environment, are seen as expressions related to the later stages of
therapy where some progress has been made towards recovery. The tree is identified by Murphy (citing Jung, 1968) as an archetypal image, which may be viewed as a profile view of the self. One feature of these landscape images is the symmetrical positioning of two trees, one alive and one dead, which may “represent an expression of the two opposing aspects of the ‘self’” (p. 106), presumably the desire to thrive juxtaposed with the desire to starve to death.

Schaverien (1989) states that “the initial pictures in art therapy with anorexic patients are often about food” (p. 16), which, she argues, are about both stating the problem and testing “the therapist’s reaction to her attitude to food” (Ibid). Schaverien argues that trust may develop if these images are accepted, without the art therapy “becoming a bargaining counter itself”, which can be “destructive” (Ibid). The client may then go on to make images which are not about food, which “permits her to be an ordinary mortal with ordinary worries; through the making of pictures she may redefine her existence” (p. 17).

Robin Macks (1990) describes the making of clay containers, namely slab pots, as being of particular significance for women with eating issues. Macks draws a parallel between the female body and the container or vessel, and sees the process of slab rolling in itself as indicating a difficulty in judging “appropriate thickness or thinness” (p. 27), which she describes as a metaphor for body image distortion. Macks’ work using clay is discussed in more detail in the section looking at the use of specific art media.

In the case example of a woman with anorexia described by Acharya et al (1995, pp. 251-252), rather abstract themes in the patient’s artwork are identified, including “depression and isolation”, “control and obsessions”, “danger and self-destructive behaviour”, “fertility and body image” and “family issues”. The authors argue that these themes “can be established through recurring images in the pictures” (p. 251) and that “these themes
surface for a while, disappear, and reappear some time later, or several themes exist at once” (pp. 251-252).

Art therapist Paola Luzzatto (1994b) offers a model of the anorexic person’s fragile sense of self in her description of ‘Self-World images’ – an intervention (or directive) that Luzzatto developed in her work in an outpatient clinic. Luzzatto noticed that many of her anorexic patients produced a particular kind of image, when asked to depict themselves in relation to their world: she calls this image the “double trap”. The double trap, which Luzzatto theorises from an object relations framework, incorporates both the sense of being trapped or imprisoned, and the fear of persecution if released from the prison. The image of the double trap contains themes, which according to Luzzatto, can then be worked through in subsequent art therapy sessions, eventually leading to significant psychic change.

In her case study of the double trap model, Luzzatto (1994b) cites the example of a young man with anorexia, although she states that the dynamics or themes she describes are not gender specific, and that the processes she identifies also apply to females. In another published article describing the same type of images, Luzzatto (1994a) again refers briefly to the double-trap images of three anorexic women.

With one case example ‘May’, a woman with anorexia, Schaverien (1994b) illustrates her theory of two different kinds of images, which typically occur in art therapy, as exemplified by two images May produced in art therapy. The first kind of image May drew (p. 52) is an example of what Schaverien calls elsewhere the “diagrammatic image” (1987; 1992). Schaverien describes how May did not connect her first image to her emotions. The diagrammatic image is one, which does not seem to hold particular significance for the patient. Rather, it may be produced “because the therapist requested it” (1994b, p. 52).
May’s second drawing however was different. May drew a small hunched female figure inside an oval shape. It was drawn on the back of the first image, and Schaverien (1994b) interprets it as “an eloquent image; an exemplification of a feeling rather than an explanation” (p. 58). This second type of image Schaverien identifies as the “embodied image” (Ibid). Schaverien also refers to the embodied image as an example of the “scapegoat transference” or, as previously discussed, a “transactional object” (p. 46).

The second image created by May seems to Schaverien (1994b) to be “a transactional object that was not food” (p. 58). In other words, May had attempted to enter into a meaningful relationship with Schaverien, by taking “the first tentative step in admitting to herself, and to the therapist, how she felt” (p. 60).

It is the embodied image that Schaverien (1994b) is mainly interested in here, since for her it contains the potential for change in patients with anorexia, since it can “offer a means of bringing the anorexic to a stage where she can relate directly to another person” (p. 60).

### 2.3 Dilemmas for art therapists

The previous section describes some of the features art therapists have identified in the artwork of women with eating issues, and their interpretations of these images. The following section will examine some of the emergent dilemmas identified by art therapists in treating this client group.

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8 Schaverien (1994b) uses multiple terms to describe aspects of the same phenomenon. By “scapegoat transference”, Schaverien refers to a process in which:

…the picture becomes an object into which a transference of attributes and states is made. Thus the picture comes to be experienced as holding, in substantial form, attributes which are usually considered to be intangible…this offers an opportunity for resolution and reintegration of the transference without it necessarily being enacted through the transference to the art therapist. (Schaverien, 1994b, p. 58)
Directive vs. non-directive approaches

Within the art therapy literature, there is some disagreement about the preferred approach. For example there has been an on-going debate in the art therapy literature in general about the relative benefits of directive and non-directive approaches (see, for example, Liebmann, 2004; McNeilly, 1984). The art therapy literature focusing on eating issues is no exception, and as in the general art therapy literature, there is no consensus on what is most beneficial. For example, Mitchell (1980) suggests that when working with the anorexic woman; the art therapist should work non-directively at first, until trust has been established, and initially refrain from questioning the woman about her artwork (p. 60). The aim of therapy at this stage, according to Mitchell, is to encourage the patient to “feel comfortable and be free to express herself in the setting” (Ibid). Like Mitchell, June Murphy (1984) suggests that in the early stages of treatment, “a non-directive approach would seem most appropriate” (p. 102).

Levens (1987) sees patients with eating disorders both individually and in groups over a period of 4-8 months as in-patients. Although she usually works non-directively, she acknowledges that for many, there is a need for direction in the early stages of therapy (see Levens, 1987, p. 3). This idea is in direct contrast to Mitchell (1980) and Murphy (1984), who suggest that non-directive work is more important in the early stages. Levens (1987) characterises the eating disordered patient as being “lacking in direction and autonomy”, which provides the rationale for using directive techniques in the early stages of art therapy (p. 3).

It is not always clear in some of the above literature whether the author is referring to group or individual work. The following section considers directive or non-directive approaches where group work is the specified method of working.
**Directive vs. non-directive approaches in groups**

There is similarly much discussion by art therapists on the relative merits of directive or non-directive groupwork. Waller (1993) argues strongly for non-directive group work, which is her preferred model, suggesting that the provision of themes by the conductor gets in the way of transference or group issues. As she argues, “the extent to which a conductor believes that participants in a group are able to make their own choices…is one of the main factors influencing their approach” (p. 42).

However, Waller (1993) acknowledges that despite her reservations about a “theme-centred” approach, there is scope for this type of work given the appropriate context. For example: - in “time-limited workshops…(and with) functioning out-patients with problems such as drug and alcohol addiction, eating disorders, depression and phobias” (p. 59).

Clearly one is lead to the conclusion that there is no one “ideal method” or formula for working with eating issues either individually or in groups. Realistically, the model is perhaps more likely to be dictated by the treatment facility, and indeed by economic factors, than by the preference of the art therapist. These organisational factors are not generally discussed in the art therapy literature. The relative benefits of group work have been discussed more fully in an earlier section of this chapter.

**Interpretation and transference issues**

In most descriptions of dynamically-oriented art therapy approaches, the *interpretation* of art work is seen as a crucial part of the process. Interpretation is defined by Case and Dalley (1992) as “making conscious unconscious processes…(which) puts the
understanding of this process into words” (p. 64). This process takes place in conjunction with the *transference* relationship which develops between client and art therapist. Transference is defined by Case and Dalley (1992) as “when the patient transfers strong, infantile feelings that originate from childhood experiences or early relationships onto the therapist” (p. 60). These two elements, interpretation and transference, can be seen as forming the “backbone” of an object relations based art therapy approach. There are indications in the literature, however, that working with the transference and interpretation can be problematic with women with eating issues.

Levens (1987) identifies transference issues that can arise between patient and therapist, noting that with anorexics in particular, the therapist may be perceived as “force feeding” the patient by making interpretations (p. 5). Case and Dalley (1992) make a similar point when they state that:

> Language is potentially a terrifying maternal object. The over-interpretive analyst becomes a tyrannical mother and language is integral to her power. (p. 68)

The fact that interpretation occurs in the external arena of the art-work, Levens (1987) suggests, may make it more acceptable. However she recommends that for this reason, interpretations of art-work should be “made less frequently than with other patients” (p. 5). Schaverien (1989) makes a similar point, arguing that:

> The whole relationship can be transferred to, and carried in, the pictures for a long time and progress may be made without recourse to verbal interpretation. (p. 17)

Schaverien (1989) also suggests that with this client group, it is not always desirable to work with the transference:

> Transference feelings towards the therapist may be manifest but there is a taboo on mentioning it. The therapist, by going along with this taboo, is respecting and permitting a resistance to go unchallenged…with the anorexic this respect for her tightly drawn boundary is helpful, and, in fact, enables the process of recovery. In psychoanalytic terms this would be seen as encouraging a defence which must be worked on; this would be true if there were no pictures. But in art therapy the pictures reveal far more than is consciously put into them and so the unconscious content is assimilated without verbal interpretation. Ideally the additional
understanding gained from some verbal discussion is helpful in fixing meaning and understanding, but with this client group this may not be beneficial. (p. 17)

Since working with transference and interpretation are one of the main tools of the object relations school of art therapy, clearly working with this client group can challenge the therapist to seek alternative methods of working.

**Process vs. content**

It has become something of a cliché in art therapy to state that the *process* of art-making is as important as the art work or *product*. The reality however, particularly when writing about art therapy, is that authors often focus on the finished product because this is what they still see in front of them once the session is over. One approach, outlined by Makin (2000), is to view the art work “as a concrete way to mark changes and progress” (p. 50).

Rabin (2003) for example, focuses on the finished art work in her research with women with eating issues. The art-making process is only explored when her clients mention this in their self-report, and often this is some time after it was made, when they compare art works on the same topic, made at two different stages in therapy. “Jessica” is quoted describing her first body contour drawing (BCD) as follows:

> It was like drawing a paper doll…I knew it was me, but it was flat – I was drawing a picture inside a picture…It was like a cartoon…I tried to make everything exactly right…I worked so hard to stay in those boundaries and I was all over the place. (p. 83)

Describing her second BCD:

> The second one was me – I was just drawing what I felt like or who I felt I was…I didn’t think about what it looked like, and it looked like me…I just feel calmer…I’m less upset by little things. (p. 83-4)

The therapeutic process, in this case, is the transition from one image to another, and provides, according to Rabin (2003), a record of the client’s progress.
Makin (2000) comments on Wood’s (1996) assertion that:

Both Schaverien and Murphy see the ‘therapeutic agent for change’ in art therapy to be the client’s communication to herself through unconscious projection into the image when looking at it after making it. (Makin, 2000, p. 50)

Levens (1994a), however, suggests that discussing the art-making process with women with eating disorders may prove more fruitful than discussing the content of the finished image alone, since there may be more connection with the emotions arising from the process (pp. 162-163).

To illustrate this point, Levens (1994b) describes a case vignette of a woman with an eating disorder, ‘Lee’, whose sister had been sexually abused by her father. Lee created an image, which initially she was only able to describe as “my confusion on paper” (p. 87). Lee was encouraged by Levens to “retrace the process of making her picture” (p. 88). Levens describes the stages that Lee went through to complete her image, which she entitled “Sexuality”. These stages included Lee creating a pencil drawing of a naked female, reinforcing the outline with black paint, painting a box around her head, clothing her body, and scribbling over the outline very intensely (p. 86).

By encouraging Lee to construct a narrative of her art-making process, Levens (1994b) was able to facilitate Lee’s discussion of her vulnerability, shame and guilt in relation to her (female) body. Lee had also illustrated her wish to disconnect herself from her body in the process of putting a box around the figure’s head, as well as her anger that she turned against her body (pp. 88-89). Levens describes Lee’s art-making process as symbolic of self-mutilation, in a similar way that her earlier descriptions of “vomit pictures” are seen as examples of art being used as an alternative to more destructive methods of “acting out” (1987, p. 3).
In addition, by analysing the process, Lee was able to identify a pattern of attempting to communicate through art, which she would then sabotage through an attack on her image. This would lead to rage and despair which she was able to connect with earlier rejection by her mother. In this example, not only did the artwork contain within it a record of its own creation, it also provided a metaphor for the therapeutic process itself, and Lee’s ambivalence about self-expression within the context of therapy.

This example describes how art therapists may use the art therapy process, in discussion with clients, to increase self-awareness and examine (for example) self-destructive behaviour within the ‘here and now’ of the therapeutic relationship.

David Mann (1990) argues that the art-making process may reveal defences and resistance, using the case example of “Ms X”, a woman with anorexia and bulimia. He describes how:

…she would flood me with pictures and associations. Four or five pictures in each session and a plethora of associations and memories attached to each…I suggest that it was in precisely this mass of material that she expressed her resistance to the therapy…by flooding the therapist with images and associations she reproduced both anorexic and bulimic experiences. (p. 10)

As with Levens, (1987; 1994b) Mann (1990) highlights the parallel between the qualities of the art-making and the qualities of the eating issue. These examples indeed suggest the need to pay attention to the art-making process as much as the finished art work. They also suggest that the use of art provides a safer means of defensive behaviour when compared for example with self-starving or bingeing.
Dilemmas for art therapists: Summary

This section of the literature review has considered some potential “dilemmas” for art therapists, namely whether to work directively or non-directively, whether to make interpretations of art work, and whether to focus on the content or the process of art-making. As we have seen, working with this client group challenges object-relations trained art therapists to consider alternative approaches, such as working directively rather than non-directively at times. It questions the usefulness of accepted techniques such as interpretation and working with the transference. It also cautions us to pay attention to the process of art-making as well as the art work itself. The next section will look at some of the specific directives suggested in the art therapy literature.

2.4 Specified themes: Art therapy as “special recipes”

Many of the art therapists, who have written on this topic, make a number of suggestions about appropriate themes or directives for this client population. This is stated with the proviso that as we have previously discussed, there is some debate about whether directive or non-directive work is preferable with this population. The first group of suggestions is for working with individuals and the second, larger group is for group work directives.

Individual themes

The majority of themes suggested in the literature focus on the portrayal of the self, and the exploration of feelings, which many authors have highlighted are crucial issues for these clients. Mitchell (1980, p. 60), for example, suggests a number of assignments it might be useful to undertake in art therapy with women with eating issues, once a therapeutic relationship has developed. These include a self-portrait, an idealised self
portrait, a family drawing, drawings based on feelings, portrayals of emotions, and desires for the future.

Darcy Lubbers (1991, p. 52) describes various aspects, or themes, of individual art therapy treatment, including assessment, self image and body image, ventilation of feelings, family dynamic issues, issues of control, cognitive distortions, personal effectiveness, and individuation, as they relate to both anorexic and bulimic patients. These themes are explored in highly structured activities, such as the House Tree Person assessment drawing (p. 53), and making a feelings chart (p. 57) to assist with ventilation of feelings.

Rabin’s (2003) research utilises various themed art tasks, such as the body contour drawing, the self box, chromatic family line drawing, house/tree/person/person/animal, body image mandala and self image mandala. In Rabin’s work which is research based, these tasks are all completed twice during therapy, and the client is asked to notice differences between their first and second images.

*Group themes*

The focus in group work, as in individual work, is on the self and the expression of feelings. Numerous group directives are mentioned in the literature. For example, in British art therapist June Murphy’s (1984) clinical practice, the adolescents begin with non-directive individual sessions whilst still on bed rest as part of a behavioural contract. When they have gained sufficient weight, these patients may be referred for group art therapy, which includes “projective techniques, art therapy games, face painting, and the construction of imaginary worlds through paper and clay” (Murphy, 1984, p. 102).

Murphy (1984) describes one aspect of the Goldsmiths research referred to earlier, as consisting of group sessions with eating disordered patients. These sessions involved:
A series of exercises concentrating on certain parts of the body...using video, masks and make-up, paintings of ideal self, and a group activity of making life-size models which acted as their ‘other’ selves. (p. 103)

The activities Murphy (1984) describes are resonant with the “true self/false self” split mentioned elsewhere by Lesley Fleming (1989), which are based on an object relations developmental model. Fleming’s description of her clinical work links the use of particular art materials to stages of therapy, and of individual creative development:

Like play, making art allows trial action and can lead to experiences of mastery; these experiences increase self-esteem and further strengthen the boundaries of the self. (p. 282)

Art therapy conducted by Fleming (1989) takes place in a group setting, “with a focus on individual developmental concerns” (p. 302). Stages of art therapy are characterised by different themes, as well as the use of different types of art materials. Early work for example involves themes such as creating trust, safety and a holding environment, rather than encouraging emotional exploration. At this stage art materials are reassuringly familiar (pp. 283-284).

In her case example, “Crystal”, Fleming (1989) describes early stage activities such as imagining a colour that helps participants feel peaceful or whole, making a symbol to represent the physical self within a life-size body outline, and making a self-box. The self-box becomes important later on, in the mid-stage of therapy, when Crystal expressed a wish to destroy it, since in her words “it was made up of what others had created” (p. 294). This awareness of the “false self” was, according to Fleming, a significant insight in Crystal’s growing sense of her own needs and identity (p. 295).

In the mid-stage of Fleming’s (1989) art therapy work, the focus is on the expression of needs and the development of the self. If anxiety occurs, “returning to materials that the patient has experienced as safe or soothing is encouraged”, as in the example cited above.
Also in this stage, “aspects of the self are pictured, and integration of part-selves is supported by placing images within a container or shape such as a circle” (Fleming, 1989, p. 284-5). Examples of exercises used include: - picturing liked and disliked parts of their bodies; using clay to make animals to represent two different aspects of themselves; “picturing an important family relationship and your needs within it” (p. 290); and making early, current and future selves, also in clay. Family themes are further explored with abstract family portraits, using colour and shapes to represent family members, and drawing family members and their personal space, including boundaries. Media such as paint and collage, and images of nature, are used to soothe when activities bring up painful feelings and memories (p. 279). Further activities include drawing parts of themselves they wish to keep, and freer, less directive tasks.

Fleming (1989) then describes themes used at the termination stage, including loss and separation anxiety:

Tasks emphasise expression of feelings and depiction of memories of early losses. A review of the artwork together with drawings and discussion of the patient’s changes during hospitalisation assist in closure. (p. 285)

Patients are asked to make personal directories of colours and symbols to represent feelings, as a preliminary to a second drawing. Another suggested activity is to depict the road of their life, “using colours and symbols to review life and their period of hospitalisation” (p. 300).

An art therapist and a social worker facilitated the art therapy groups described by Morenoff and Sobol (1989). Examples of the art themes introduced are a self-portrait, an alternative self-portrait, an early memory, and a positive childhood experience with their mother (p. 147).

With regard to specific themes, the use of body outline drawings is mentioned by Woodhead et al (1997, p. 295). These drawings can provide women with a ‘mirror image’ of their body, which, the authors suggest, may challenge the distorted body image
that exists in their mind. Self-perceptions can also be explored through the use of self-portraits, and specific fears can be addressed through themes such as “myself when I have reached target weight” or “myself before and after a meal” (p. 295).

The preceding section of this chapter gave an overview of some of the themes suggested by art therapists in both individual and group work with women with eating issues. There is much greater consideration of theme centred work in descriptions of group work than of individual therapy. It may be useful to consider the paradox of working on issues of selfhood within the context of group, rather than individual therapy. As British art therapists Gilroy and Skaife (1997, p. 61) have noted, descriptions of theme centred work, (see e.g. Fleming, 1989; Lubbers, 1991; Mitchell, 1980) and specific techniques, are largely given by North American art therapists.

Specific media: Art supplies as “special food”

Several art therapists, particularly in the United States, have written about the special qualities of certain art media, which they find beneficial in their work with women with eating issues. In the case of Fleming (1989), she comprehensively outlines the use of different media at different stages of treatment, whereas other authors write about the benefits of the particular art media they favour.

The expressive therapies continuum

Fleming (1989) incorporates the use of media into her developmental approach outlined in the previous section. This method of working is influenced by the expressive therapies continuum (ETC) (Kagin & Lusebrink, 1978), which proposes the selection of art media according to their perceived utility at particular stages in art therapy. In the early stages
of treatment, Fleming (1989) suggests the use of “non-threatening art materials such as pencils, markers, and crayons, which tend to encourage cognitive responses” (pp. 283-284).

Later on, when the therapeutic work intensifies, Fleming (1989) uses materials such as soft pastels, oil pastels, and paint, which according to her:

…promote the expression of affect, encouraging self-investigation. Thick paint may encourage regression because of its smearing, running, or its similarity to body fluids. Clay can also invite regression; however its cohesive qualities support reintegration. (p. 284)

In the termination stage of therapy, there is a return to materials used in the beginning stages of therapy. Fleming (1989) suggests that:

…control over the art materials provides a substitute, or outlet, for wishes of control previously manifested in eating behaviour and preoccupation with body image. (p. 285)

Fleming (1989) is unusually detailed in her description of the developmental use of materials over the course of therapy. She takes into account the stages of therapy and matches these stages with specific suggested media. The following examples cite the use of particular media as preferred by various authors.

**Clay**

Several art therapists have written about the use of one particular preferred medium in their therapeutic work with this client group. For example, Robin Macks (1990, p. 22), writes about the specific benefits of clay in an inpatient group for women with eating disorders. Macks argues that clay is a powerful medium for the women who attend the groups. She bases this both on her observations and, refreshingly, from her own experience:
I knew that for me, claywork had been a centering and grounding activity during a difficult time in my life. It had become a way for me to return to an inner place and connect with a deeper self. (p. 22)

As with many art therapists, Macks’ (1990) work is informed by object relations theory. She focuses particularly on the transition from the *symbiotic* stage, where the self is merged with the mother, to *separation/individuation*, where the individual develops autonomy and control (p. 22).

Macks (1990) hypothesises that the claywork process can be seen as “a metaphor for the developmental process” (p. 22), since the clay can be seen to mirror the actions of the individual, as the mother mirrors the actions of the infant. Similarly, the clay offers sensuous experiences which parallel the baby’s sensuous exploration of the mother’s body which “is a way the infant delineates body boundaries” (p. 23).

Macks (1990) argues that the woman with eating issues:

…has an unresolved period of differentiation which extends through rapprochement, and as a result has a distorted body image and unclear body boundaries. (p. 23)

She suggests that clay has unique qualities for working with these issues in the context of a therapeutic relationship. This includes not only the initial creation of the clay object, but also the drying out, firing and glazing stages, which require ongoing involvement from the patient, whose ‘*object relatedness*’ can be observed by her ability to engage in this ongoing process.

Macks (1990) also explores the symbolism of clay vessels and the relationship between this and the female body. In one group she comments that:

It is curious that many of these women created containers that were square and angular rather than rounded and flowing. The square form is completely at odds with the body shape. Perhaps it is another attempt to control the body. It appears to be a concretisation of the denial of the feminine. (Macks, 1990, p. 27)

She comments again on the same phenomenon later:
...the occurrence of the box as the container of choice for so many of my clients has demonstrated the severity of their disability to internalise a nurturing mother. It seems to be a representation of the constrictiveness of the mother inside. (Macks, 1990, pp 28-29)

Transference issues can also be identified, via the art work, as in the following example. Several women in the clay studio use existing bowls to form moulds for their own clay vessel. Macks (1990) sees this as an example of two kinds of containment:

The therapist is containing the patient not only through her presence, but through her association with the container (found in the studio) which is being used as a mould. (pp. 27-28)

**Collage**

Echoing the developmental approach outlined above by Fleming (1989), Makin (2000, p. 91) describes collage as a relatively non-threatening medium, which does not require any particular skill (such as drawing), and which is therefore suitable to use in the introductory stage of art therapy.

Helen Landgarten (1993) writes about the particular benefits of magazine photo collage as tools for assessment and therapy, describing in some detail the specific techniques and exercises she has developed using collage in assessment and treatment. She includes two brief case studies of women with eating issues, one with anorexia and one with bulimia, in the presentation of her assessment method (pp. 30-36: pp. 44-53).

Landgarten (1993) also makes some interesting suggestions about the cultural sensitivity of using magazine collage, but with reference to race rather than gender issues (p. 5). Although she writes about the importance of finding magazine images which reflect racial diversity, and which in particular are culturally appropriate for her clients, she does not comment on the gender issues inherent in magazine images and the messages these images provide to women on body size.
An earlier article by British art therapist Mary-Jayne Rust (1987) develops this issue further. Describing her work with women with compulsive eating issues, she suggests that this very choice of art media, namely collage using magazine images, is particularly apt for this client group. These women are aspiring to “recreate themselves” in those images, hence:

…it is using the very material that so subtly pervades, persuades and influences women – and so provokes them. (p. 153)

Holly Matto (1997) also comments on the cultural aspect of using of collage, stating that it:

…it can be an excellent way to facilitate discussion about internalised cultural messages that lead to the development of…dysfunctional thoughts and negative self-statements. Collaging can be used in group settings to instigate dialogue about the role culture plays in contributing to the maintenance of eating disorders. (p. 351)

There is further discussion of Rust’s (1987) and Matto’s (1997) work in chapter four, which examines feminist approaches to women with eating issues. However, they both raise an interesting point about the appropriation of images by women, implying that they can somehow take ownership of them, and turn them into new images that have an alternative meaning. Weiser (1993, p. 29), writing about making collage from photographs, makes a similar point about the whole collage being more than the sum of its parts.9

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9 Kathleen McDonnell (2000) raises a similar issue in her exploration of the way that children engage with popular culture. As an example, she cites the Barbie doll, which many feminists believe are influencing girls with negative body image messages. McDonnell however argues that:

The truth is that girls are constantly subverting the script laid out in the Barbie ads. However much Mattel may intend Barbie to be a paean to consumerism and traditional notions of femininity, it’s been my observation that little girls remake her in their own image and use her as a celebration of their own femaleness. (p. 58)
Mask-making and video

Murphy (1984, p. 103) describes the use of video, masks and make-up in the (1981) Goldsmiths’ College research group mentioned earlier. Various activities, including “a group activity of making life-size models which acted as their ‘other selves’” (p. 103) were selected and video taped by the participants, in order to directly confront their distorted body image. As Murphy notes, the results of this group are still unpublished, which given the lack of research in this area is disappointing.

Hinz, and Ragsdell (1990) also describe the use of mask-making and video in ongoing psychotherapy for bulimic women at a university counselling centre, in Louisville USA. This article is useful in documenting the resistance encountered by the therapists in their attempts to explore difficult issues with women who were probably not ready for this to occur. The use of video cameras in particular was shown to have a dramatic negative impact on the participation rates in the group (p. 260).

Originally this mask-making and video technique had been used with outpatients to encourage dialogue between different aspects of the self, represented by masks. The process firstly involves making a mask, with the woman then asking questions into a video camera whilst wearing the mask. The authors state that “introduction of this exercise was followed by a precipitous drop in attendance, to an average of two per session”, from 6-7 per session previously (Hinz et al., 1990, p. 260). The activity brought a great deal of resistance, both during mask construction and using the video. Previous art therapy projects had been seen as beneficial. These projects had focused on food and family relationships, not “on the innermost self”.

Hinz and Ragsdell (1990) argue that this mask-making work appears related to the concept of the “false self”, which has been described elsewhere, as the outward ‘mask’
which is adopted to respond to social demands and which covers or masks the real or
‘true self’ (Davis et al., 1981; Orbach, 1994). Hinz and Ragsdell (1997) write that:

In light of the conflict between real and false self, from which bulimic women
seem to suffer, they seemed extremely afraid to present their real self in group,
but derisive of anyone who responded to their masked or false selves. (p. 260)

The authors conclude that the three women who were able to conclude the task were at a
more advanced stage in their recovery, less influenced by others’ opinions, for example,
and “struggling with issues of independence and personal responsibility” (Hinz et al.,
1990, p. 260). They argue that the task was too confronting for the rest of the group.
This difficulty underlines the importance in art therapy groups, of ‘pitching’ therapeutic
activities which both support and reflect the position of the participants at the time. For
Hinz and Ragsdell, directive strategies, such as using masks and video, can be beneficial.
However, they can also be experienced as too threatening if participants are pushed too
far, or too fast, in a direction they are not ready to move towards.

Holly Matto (1997) describes the use of mask making in an art therapy group, to assist
participants to differentiate between their false and true selves. A mask is made of the
false self, which is then “decorated and hung on the wall as a way of externalising one’s
false self and as a way to dialogue with the visual image itself” (p. 352). Matto argues
that the very process of making the mask “can parallel, for some clients, the very
restricting societal pressures and influences that they have felt during their own
developmental process” (Ibid).

Cooper et al. (2003, pp. 187-188) give a case vignette of a woman, ‘Jo’, who used mask-
making to reveal her emotional pain, and, unusually, ‘Jo’ is given a voice, when she
states: “what I’ve done my whole life, isolate and hurt myself, doesn’t work. I can now
see that I have to find another way to live” (p. 188).
2.5 Summary of chapter two

This chapter has described some of the key approaches noted in the literature that have been taken by art therapists in treating women with eating issues. It has outlined some of the psychological features that need to be considered in treatment and suggested ways in which art therapists have addressed these features. In addition, the benefits of specific art materials have been examined.

Overall there is consensus in the current literature that the development of the self, identity and boundary issues are core factors in working with this client group. Themes arising from these core factors include control, autonomy and relationship difficulties. Emergent from this literature review is an emphasis on the difficulty of working with these clients, since they challenge the usefulness of several of the fundamental precepts of art therapy practice. The following chapter will provide a critique of the approaches outlined in this chapter.
Chapter three: Critique of art therapy with women with eating issues

Starvation is a form of communication that offers the body as a text to be read. Its message articulates a subtle cultural protest. The protest concerns the societal ideal...her emaciated form reveals the oppression of thinness by manifesting a dangerous exaggeration of this ideal. (De Pree, 2004, p. 55)

3.1 Introduction

The previous chapter described art therapists’ approaches to women with eating issues in some detail. It identified themes in the literature with regard both to the art therapists’ theoretical approach to eating issues, and also their methods of treatment. This chapter now takes a more reflexive and critical appraisal of these theoretical approaches and this treatment. The aim in adopting such an approach is to identify shortfalls and the shortcomings of the existing literature.

As we have previously noted, there is a large body of literature on art therapy and eating issues, written mainly in the UK, and the USA in the past twenty five years. In summary, the British literature is supportive of non-directive, less structured, and more theoretically-biased work, which is largely based on an object relations psychodynamic framework. The North American literature is more eclectic in approach, but indicates a preference for more structured and theme-centred work, and is more descriptive of practice (Makin 2000).

Art therapy is seen as potentially very useful, as it provides women with eating issues with an alternative and concrete means of relating both to the self and others. It is
suggested that 'just doing art' is not enough, however; but rather that the art therapy process has the potential to develop insight and the capacity for metaphorical thought, which then need to be integrated into the personality (Levens, 1990, p. 280). Additional benefits of art therapy claimed in the literature, and discussed in the previous chapter, include: - it provides a ‘mirror’ to the client of her eating issues, which may assist in developing insight (Murphy, 1984, p. 108); it requires active participation or involvement (Levens, 1987; Murphy, 1984); it has a soothing function (Fleming, 1989, p. 279); it can contain chaotic feelings/thought processes (Matto, 1997, p. 348); it avoids defensive intellectualisation (Levens, 1987); and it promotes spontaneous individual self-expression (Mitchell, 1980, p. 58; Robertson, 1992, p. 71). In addition, art therapy groups are thought to combine these benefits within a framework of social support and interpersonal learning (Ball et al., 1996).

The bulk of the art therapy literature in this field is descriptive of the aetiology of serious eating issues, and of the art therapist’s approach. It frequently takes the form of a case study narrative, either of a single or small number of clients. It can therefore be instructive as to the nature of eating issues and offers some useful considerations for therapists. Art therapists often place a great deal of emphasis both on their opinion of what was helpful for the client, and, using an object relations framework, on their interpretation of the art work produced by the client. This strategy attempts to make sense of the art from the art therapists’ perspective, through the lens of object relations. This often occurs without reference to the client/s that produced the work. This aspect of the literature is less useful for art therapists who utilise different theoretical frameworks, or who prefer to base their understanding of the art therapy process on client derived or systematically gathered direct evidence rather than interpretations based on anecdotal observation and theory.

In this critical look at the art therapy literature, I will re-examine in turn the themes identified in the previous chapter, and attempt to determine the evidence that these
themes can assist us in evaluating the benefits of art therapy practice with this client population. I will proceed through this review in the same order as in chapter two, examining each theme or issues with regard to this overall evaluative goal. I will also consider factors which are largely absent in the art therapy literature, specifically a thorough exploration of socio-cultural issues, clients’ voices, and alternative approaches. For this latter section of the chapter in particular, I will draw heavily on the work by Michele Wood (1996), which provides a critique of the British art therapy literature in this field between 1980 and 1996.

3.2 Characteristics of women with eating issues and therapeutic factors identified by art therapists

This first section looks at the characteristics or aetiology of women with eating issues, and critiques the suggested benefits of art therapy to address these characteristics.

Autonomy of self and identity issues: Art therapy as self-actualisation

Art therapy is claimed to assist in regard to the development of the autonomous self, which is seen as a key task for women with eating issues (Bruch, 1974, 1978, 1985; Fleming, 1989; Mitchell, 1980; Rabin, 2003; Robertson, 1992; Welsby, 1998). Art activities are often focused on assisting the client to increase her self-awareness and sense of identity. Rabin (2003, p. 3) for example argues that art therapy can address the incongruence between the client’s verbal and non-verbal communications, by reviewing art work made earlier in treatment and contrasting it with statements made at the time.

Fleming (1989) uses an object relations framework to introduce concepts of the true and false self, which may prove useful in our understanding of eating issues. Fleming
provides us with many examples of activities, and outlines the stages of treatment within which those activities are utilised. The ultimate aim of her approach is to enable the emergence of the true self.

A common oversight in many art therapists’ accounts of treatment is the linking of theory and practice. We have to take it for granted that the approach specified addresses the issue outlined in the theory. One way this oversight could be addressed is to also give clients’ accounts of treatment, as well as clinicians’ accounts.

Issues of autonomy are frequently cited in the art therapy literature, however the fact that these issues are not viewed through the lens of normal adolescent development, or through a gender analysis, is problematic. In other words, the frame of reference is too narrow, and does not consider socio-cultural biases.

Autonomy is paradoxically a cultural issue, which is particularly positively determined in Western culture. The development of autonomy clearly needs to be placed within a cultural context, which again is missing in the art therapy literature. For example, women may find it more problematic to develop self-autonomy than men, due to the influence of gender role expectations in general and the role of mothering in particular, which stresses the need for connection to others rather than individual self-hood (Steiner-Adair, 1989). Therefore autonomy issues are likely to be more challenging to all women, not just those with eating issues.

The major problem with regard to autonomy, however, is the fact that the majority of art therapists do not enable, or provide an avenue for, their clients to speak about their own experiences of art therapy. By denying them a voice in the literature, art therapists are limiting their clients’ potential for self-actualisation and autonomy. This suggests to me a counter-transference issue which may reflect the mother-daughter relationship, recreated
in the therapeutic alliance. This issue has not been addressed to date in the art therapy literature.

Autonomy within the context of treatment

Some authors have argued that art therapy can be beneficial since it differs from the mainstream biomedical approach, in which clients are the passive recipients of treatment (Bruch, 1974; Robertson, 1992). This view has not however been explored fully in the art therapy literature, largely to do with the absence of an analysis of the treatment milieu (M. Wood, 1996, p.18). Art therapy has usually been described as a discrete intervention, without much reference to the context of treatment. This will be discussed in a later section of this chapter, in which I examine the issues which appear to be missing from the art therapy literature.

Active participation: Art therapy as self-healing

Various authors have suggested that art therapy provides a fairly unique benefit, that of active participation in the therapeutic process by means of art activities (Bruch, 1974; Jung, 1954a; Levens, 1987; Murphy, 1984; Woodhead et al., 1997). Art therapy requires the client to get involved in her own recovery and this is seen as providing a corrective experience in itself. Along with other action methods, art therapy is often cited as being preferable to medical, behavioural or verbal therapy where the client is the passive recipient of treatment. This provides a rather promising argument which relates somewhat to the art-making process being of itself more therapeutic than the viewing of the art-product. This claim seems to be an important one and is not one which I am disputing in this critique of the art therapy literature, indeed it will be addressed in more
detail in chapter five. What is missing in this case is the clients’ statements to this effect, which could provide evidence of this important claim.

Splitting and polarisation: Art therapy as an integrative process

Art therapists such as Levens (1990; 1994a; 1994b) argues that art therapy can assist with the integration of ‘split off’ elements of the personality. This claim, as we have seen, is based on object relations theory, which hypothesises that in early infant development, the baby splits off aspects of the mother into good and bad objects, before being able to integrate the two opposing parts into a whole (Winnicott, 1980). Levens’ claim however is not supported by descriptions of how this integration takes place. It seems mainly to be based on the theoretical construct of object relations, rather than on statements by patients, or evidence sought through the art work.

Similar statements made by art therapists and other clinicians stem from the observation that women with eating issues do indeed present with various polarised attitudes and behaviours. As we have previously discussed, the split between the true and false self, also derived from object relations theory, has been mentioned in the art therapy literature (Fleming, 1989). Other splits identified by clinicians include: a mind/body split (Bruch, 1978; Levens, 1994a; Mitchell, 1980), a split between actual mind and negative mind (Claude-Pierre, 1997), and a split between life and death (Maclagan, 1998).

In addition, Levens (1994a) and Makin (2000) have both written about “the black and white thinking patterns of anorexics” (Makin, 2000, p. 106). This statement could be taken as further evidence of the object relations approach, but could equally refer to the concept used in cognitive behavioural therapy (CBT) of “black and white thinking”, which has been identified as a cognitive distortion. Generally these splits are
characterised by looking at issues from either extreme rather than from the ‘grey area’ in the middle. This presentation is not under dispute.

We should however be careful about the conclusions that are drawn from these observations. For example, one of Makin’s (2000) patients, “Anne” writes:

Moving from my depressive thoughts in black and white, I have shifted to more variety of colours and media. (Makin, 2000, p. 192)

This statement, which is referring to Anne’s engagement with art therapy, seems simply allude to the concept that the client perceives her depression as lacking in colour, rather than as evidence of psychological splitting. It also points to the suggestion that her artwork is seen by Anne as reflective of her mood change, without necessarily being the cause of it.

It may be however that the tendency towards extremes is also a feature of adolescence, and as such is related to a later developmental stage than that hypothesised by the object relations school. The fascination with (visual) extremes is also a feature of the popular media, which frequently focuses on the eating issues of the rich and famous, in particular the very thin and famous; and the fashion industry, which uses increasingly thin models to display the latest winter collections (Morgan, 2000). This represents a sinister parallel to eating issues in the cultural milieu in which it occurs.

Body-image distortion: Artwork as a mirror to the body

Many art therapists have identified a distorted body-image as a feature of an eating disorder (e.g. Murphy, 1984, p. 98). This distortion of body image can however be seen as being ‘normal’ within a particular demographic. Crisp (1980) for example suggests that:

…most adolescent females …consider themselves fat and…overestimate…their shape and size in association with a sense of distaste or disgust. (p. 15)
We should therefore be cautious about claiming that distorted body image *in itself* is a feature of eating issues, but perhaps view it as a feature of Western culture’s preoccupation with slender images of women. Again the ‘symptom’ looks very different if it is seen within a cultural context. As Morgan (2000) writes:

> The link between our own body image and eating disorders becomes critical if current idealized body images are characterised by a degree of thinness which is unobtainable/unachievable by most dieters. (p. 17)

The existence of distorted body image is not being disputed. We shall now consider art therapists’ claims that distortion of body image can be changed through the use of art therapy, particularly with reference to the ‘body outline drawings’ described by various authors (e.g. Crowl, 1980; Woodhead et al., 1997). Clearly at a concrete level, art therapy can provide a mirror to the woman with body image distortion, since the outline drawing will give a fairly accurate representation of the woman’s actual size.

Art therapist Mury Rabin (2003) researched the utility of various art therapy tasks, including body outline drawings, in her phenomenological study of individual art therapy with women with eating issues. She claims that “the task puts the client in touch with the reality of her physical size” (p. 42). However, the fact that the task is repeated and is part of a whole series of related tasks makes this more complex to analyse. Therapeutic change, for Rabin, seems to be evident as much in the comparison between first and second drawings, than in the inherent nature of the task itself.

This observation in relation to Rabin would support the critique that the task, like many other art therapy directives which explore issues of self, are useful in their *reflection* of the client’s issues at a particular stage in treatment rather than being inherently *curative*. We should remember that a woman with a distorted body image may look at her reflection and see a different sized person in the mirror. The mirror image is the clearest indication of actual size, and it still does not convince the woman with eating issues of
her real size. The only advantage of the body outline drawing, over the mirror itself, is the fact that the drawing continues to exist and can be used retrospectively, as Rabin describes.

**Relationship with the mother: Art work as a container within the therapeutic relationship**

In the art therapy literature, the relationship between the woman with eating issues and her mother is most often identified as problematic (Levens, 1987; Murphy, 1984; Welsby, 1998) and is often described as “enmeshed”. An enmeshed relationship with the mother is potentially a problem in a therapeutic relationship that focuses on transference, since the therapist wants to avoid becoming similarly enmeshed. Welsby (1998) has suggested that the art work may provide an alternative “container” for the transference and create space for the client to exist as separate from the mother. However it is important to note that Welsby’s client, Lucy, was a young woman with a mother with serious mental health issues of her own. This should not necessarily be used as a blueprint for other families with anorexic members.

By contrast, Minde’s (1993) case example of sending a postcard to a client with eating disorders rings true as it includes a quote from the client, who says: “the card told me that you would be there to help me along the road” (pp. 47-48).

As we have seen, the art therapy literature does not focus a great deal on the socio-cultural influences placed upon women who develop eating issues. Rather, there is a focus on:

…clients’ relationships with their families, particularly mothers, and with food, and their relationships with the art materials and the therapist. (M. Wood, 1996, p. 18)

The focus on family relationships in general is evidenced by the extensive use of family therapy as the psychotherapeutic model of choice in treatment of women with eating
disorders (see e.g. Bruch, 1978, p. 106; McDermott et al., 2002). However, as we have seen, it is the relationship with the mother that is most frequently cited as problematic (Eichenbaum & Orbach, 1983; Luepnitz, 1988; McNulty, 1998; Orbach, 1994). Other family members, or indeed peers, are not often mentioned.

This phenomenon may be a reflection of the narrow focus of object relations theory itself. Luepnitz (1988) argues that object relations theory in particular, which places particular significance on the early infant–mother relationship as the model for psychological development may have resulted in greater incidences of “mother-blaming” than other psychoanalytic models. As McNulty (1998) points out, other significant relationships, for example between fathers and daughters, and between heterosexual women and girls and their male partners, are often ignored (p. 22).

Kearney-Cooke (1989, p. 14) argues that “mother-daughter transmission of body image is another salient factor in body image development for girls”. An issue, which is not often raised in the clinical literature, is the observation that mothers of women with eating issues often have body image and eating issues themselves (Wooley & Kearney-Cooke, 1986, p. 478). The positive body image that girls need to develop is something that is directly related to the body image of their mother, which suggests that eating problems are at least in part a learned behaviour rather than evidence of a toxic, dysfunctional relationship.

Control/perfectionism: Art therapy as mastery

Various authors, for example Levens (1987); Matto (1997), have argued for the value of art therapy in enabling clients with eating issues to gain mastery over the materials. They have suggested that paradoxically this enables them to let go of their need for
perfectionism. However, the need to get something right may in some cases make art a very scary concept for those who do not feel skilled in that area.

The art therapist may believe that the client would benefit from the art activity, but if we accept the metaphor of art materials as ‘special food’, no amount of persuasion will convince a woman with anorexia to try this special food against her will. It may only be in retrospect that the client will be able to identify their achievement in engaging in art materials in spite of their fears of “letting go”.

*Overcoming denial: Art work as a mirror to the eating issue*

The use of art has been described in the art therapy literature as a means of overcoming denial and defensive behaviours. However, art can also be used defensively, as the following examples will demonstrate.

In one case study with a woman suspected of being sexually abused, David Mann (1990) argues that the art-making process may reveal defences and resistance, using the case example of “Ms X”, a woman with anorexia and bulimia. He describes how:

…she would flood me with pictures and associations. Four or five pictures in each session and a plethora of associations and memories attached to each…I suggest that it was in precisely this mass of material that she expressed her resistance to the therapy…by flooding the therapist with images and associations she reproduced both anorexic and bulimic experiences. (p. 10)

Mann (1990, pp 5-14) described the woman’s use of “art as a defence mechanism against creativity”. Mann’s definition of creativity is as follows:

The ability to experience change; to be alone and abandon or suspend one idea and survive the uncertainty that bridges the birth of a new idea…to be open to experience something different…to synthesise and conceptualise…new developments in psychic material. (Mann, 1990, p. 5)
Clearly, according to Mann the use of art does not guarantee that it will be utilised therapeutically but may in fact serve to maintain the defensive position of the client.

Similarly Wood (2000, p. 175) has described a group which used collage in a “defensive” manner through the use of words rather than images, which arose spontaneously in her group work with women with eating issues in a London psychiatric hospital. These collages were “made up of words cut up from magazines” (p. 175) and in Wood’s view “seemed to provide a means of resisting the therapeutic process while staying within the original brief of the group” (Ibid). She believes the collages were “an expression of what has been termed the ‘anorexic defence’, where clients withdraw and hide behind other people’s words” (Ibid), rather than being a conscious expression of self.

As we have see in the previous chapter, authors such as Levens (1987) and Murphy (1984) have suggested that art therapy, by providing a “mirror” to the woman with an eating issue, can assist in developing insight and self-understanding.

In an example from the literature, Acharya et al (1995), described the art of one woman with serious eating issues who attended an art therapy group in hospital. The authors state that she did not improve, but they argue that the art she produced was seen as providing insight into her condition (p. 251). In this case at least, insight was not in itself therapeutic. Bruch (1982) has argued that the therapist’s role in treating eating issues is “not so much to give insight about the symbolic significance of the symptoms as to help the patient with the way she faces the realities of her life” (p. 1536). As she acknowledges, this presents a challenge to psychoanalytically oriented psychotherapists (Ibid).

Fabre-Lewin (1997) argues that art-making has been described as making visible:

Making marks to create images with art materials is a ‘mute’ expression of the body/world relationship. Pictorial images are seen as the manifestation of a person’s self-realisation. And yet, the urge to make form to reflect our
relationship to the world, within the arts process is more than a matter of visibility. (p. 121)

Fabre-Lewin suggests it is as McNiff (1992) describes it, that the physicality of painting is what activates the change process:

…the material processes at work in the act of creating have greater potential for transformation than the notion of ‘changing the intangible idea of self’. We do not live independently of things, we are shaped by the dialogues between ourselves and the images and objects around us. In this way the pictures become the agencies which assist in restructuring consciousness. (p. 121)

Thus for Fabre-Lewin, making images is not just about representation of a problem in order to solve it. This suggest that the physical process of art-making being the crucial factor rather than the depiction of the problem in visual form. This is addressed in the following section.

Concrete thinking: Art therapy as bridge between inner and outer worlds

As we have seen, Mary Levens (1987, p.3) argues that the individual with eating disorders is “unable to use psychological metaphors”, which leads her to use her body to express herself. She builds her whole approach on this concept, which we should perhaps consider carefully given her insistence on its importance. It is not clear whether Levens’ assertion about the inability to think in metaphors can actually be accepted as a given. It should also be noted that in certain articles, Levens (1990) is actually referring to women with severe mental health issues as well as eating disorders, and these may not be representative of the entire eating issues population.

The ability to think in metaphors could be understood as a cognitive developmental milestone, which implies a cognitive developmental delay of the woman with eating issues. This does not seem to be borne out by the fact that many young women with
eating issues are in fact extremely academically focused and highly developed cognitively.

Perhaps the allusion is more towards emotional rather than cognitive processes. For example, the psychiatric term *alexithymia*, literally meaning “no words for feelings” (Nehrlich, 1999, p. 3), has been increasingly used in psychiatry to describe “a cluster of deficits in the capacity to process emotions from the cognitive perspective (which)...clearly appears to be relevant to the eating disorders” (Ibid).

Interestingly, Nehrlich (1999) reports that five content areas have been identified by Taylor, Bagby and Parker (1994) in relation to alexithymia, including “lack of introspection” and “impoverished fantasy life and poor dream recall” (Nehrlich, 1999, p. 4). This seems to resonate with Levens’ (1987; 1994a) hypothesis that women with eating issues are unable to think in metaphors.

However, it would seem that this is problematic, since if these women are unable to think in metaphors, they are perhaps going to have some difficulty in making the psychological link between the artwork and her condition. As we discussed in the previous section, Bruch (1982) suggests that the therapist’s role in treating eating issues is “not so much to give insight about the symbolic significance of the symptoms as to help the patient with the way she faces the realities of her life” (p. 1536). The beneficial aspect of the concreteness of the art materials may in fact work against the need to think in abstract, metaphorical ways about her situation, in the same way that, as we have already seen, art can be used defensively as well as insightfully.

The majority of issues discussed so far relate to the development of autonomy and a sense of self-efficacy in the individual with eating issues. As we have seen this is one of the crucial tasks of these clients. The claims made for art therapy in relation to these tasks has been theory based rather than practice based. They have also been made with little
reference to the social environment within which the individual operates and the issues have developed. The following section will begin to address these social and environmental issues in more detail.

Social and cultural factors: Art therapy in context

Socio-cultural factors play a significant role in the development of eating issues (Morgan, 2000, p. 9). Social and cultural factors that we can identify as having a potential impact on the development of eating disorders, and hence their treatment, include: - the gender analysis of eating ‘disorders’; cultural attitudes towards eating and food; the process of adolescent development; and the social analysis of the treatment milieu (which in turn includes the institutional setting, the art therapist and the team) (M. Wood, 1996, p. 18).

In the art therapy literature, however, as Wood (1996) has noted, socio-cultural issues are more characterised by their absence than their presence. This absence may be a feature of the object relations bias of art therapy, which is focused on the inner rather than outer world. Some authors have attempted to address socio-cultural issues, most notably Mary-Jayne Rust (1987; 1992; 1994), who has written consistently about art therapy and eating issues from a feminist perspective. Her contribution is considered more fully in a subsequent chapter (chapter five), in which I discuss feminist perspective art therapy with these clients.

More typical of the literature however is Mary Levens (1987; 1990; 1994a; 1994b; 1995; Woodhead et al., 1997), who has also written extensively on art therapy with women with eating issues, but has rarely taken a socio-cultural perspective.

Art therapists who have written about socio-cultural issues have focused on non-Western cultures (D. Waller, 1994) or on racial minority groups within our culture (Rosal et al.,
1998) rather than exploring the relationship between Western society and the prevalence of eating issues within this society.

These issues will be examined in turn in a subsequent section of this chapter. The following section will discuss the therapeutic factors in art therapy groups with women with eating issues.

Benefits of art therapy groups: Art therapy as a social experience

Some art therapists have argued that group work is a beneficial modality in which to work, as seen in the previous chapter (D. Waller, 1993). The therapeutic factors identified by Waller (1993), are related to a particular groupwork model; they are not designed for any specified client group, and do not seem to be based on research, as were the group psychotherapy studies previously cited. Group psychotherapy literature, as we have already seen, may have more to offer us on the question of what is therapeutic about the practice of groupwork, since this is an area which has been more thoroughly researched than art therapy practice (Gilroy, 1995). However this literature does not explore what is therapeutic about the art therapy component in groupwork, the so-called “specific factors”.

Many authors have described group art therapy with this population and made various claims about its usefulness, often based on the social aspect of groups, which provide interaction outside the family (Murphy, 1984), and the knowledge that one is not alone (Fitzsimmons et al., 1996). Johnson and Parkinson (1999, p. 89) make a more specific claim: that the experience of individual art-making within a group setting is a unique aspect of art therapy groups. They have also argued that the opportunity to ‘act out’ publicly using art materials, rather than bingeing in private, has a therapeutic aspect for
women with eating issues (p. 92). However, there is little evidence of the efficacy of group art therapy with this client group.

In the group case studies in the art therapy literature, there is little comment from the group participants about what was beneficial. Again, as in the descriptions of individual processes in the characterisation of eating issues, the focus is on theory and interpretation by art therapists rather than on observation and feedback from clients.

A unique difficulty faced by proponents of group work is that it requires the presence of a ‘critical mass’ of clients who are willing participants. Fitzsimmons and Levy (1996) had problems with participation levels which they attributed to attempting to work with young people with bulimia rather than with a spectrum of issues. Hinz and Ragsdell (1990) had a similar problem of low attendance which they attributed to the introduction of mask making and video activities. Both groups had only two participants at certain times, which calls into question the definition of group work, and how many it takes to make a group.

*Descriptions of artwork: Artwork as mirror to the eating issue*

The materiality of art supplies has been correlated with the materiality of food/eating issues by a number of writers (Johnson et al., 1999; Levens, 1994a; Schaverien, 1994b). The art-making process has been compared to the bodily processes of bingeing and vomiting (Levens, 1987). Similarly, the artwork of anorexic women has been seen to have certain “anorexic” qualities, and so on, as described in the previous chapter (see e.g. Murphy, 1984). One outcome of this correlation has led to the art work of women with eating issues being seen as an adjunct to assessment and diagnosis. Clearly, the problem of anorexia is not usually one of diagnosis, but of treatment, however.
The parallel between use of art materials and food however is interesting and may give weight to Levens’ (1994a) theory of use of the artwork providing a bridge between inner and outer worlds, as a preliminary step to using metaphors.

As has been mentioned previously in this chapter, however, such theories are presented and justified through the interpretation of the artwork by the art therapist. Descriptions of art work are frequently given but clients are not often allowed to ‘speak’. Art therapists’ voices rather than client’s voices are the norm in the art therapy literature. Susan Hogan (1997b) warns against this tendency, arguing that:

Therapists providing interpretations of their clients’ art work along fixed theoretical lines are either imposing their own fantasies or that of a theorist onto the patient’s art work, or more likely a mixture of both. (p. 37)

Hogan argues for a focus on “an examination of the particular circumstances of an individual” (Ibid) rather than “over-reliance on…theoretical orthodoxy, which can obscure as much as illuminate human suffering” (Ibid).

3.3 Dilemmas for art therapists

As we have seen in our review of the literature, not all art therapists agree on their preferred approach in working with women with eating issues. Some of these differences have been hotly debated in the art therapy literature (see e.g. McNeilly, 1984). The following section revisits issues which provide dilemmas for art therapists, outlined previously in chapter two.

*Directive vs. non-directive approaches*

As discussed in chapter two, there is some debate and disagreement about whether directive or non-directive approaches are most useful for clients with eating issues. The
debate seems to centre on these women’s fragile sense of self, and the need to provide them with some structure without overwhelming them.

The preferences seem to be culturally based, with British authors generally preferring non-directive, theoretically-driven approaches and Americans preferring directive, pragmatic approaches (Makin, 2000, p. 42). Since both points of view are represented, the literature perhaps points to a need for flexibility.

In this context it is interesting to note the recent work of Susan Makin (2000). Makin describes a ‘hybrid’ method of combining directive and spontaneous approaches as follows:

…most of my sessions appeared fairly directed and structured; but beyond the initial instructions given at strategic points…patients were encouraged to be as spontaneous and creative as possible… (they) ended up with the best of both worlds. (pp. 42-43)

Rabin’s (2003) approach, which is similar to Makin’s (2000), is influenced by her adherence to the addiction model, where structure is seen as very important:

The challenge is to present the individual with tasks that require focus but also permit freedom within the framework of the art task. Each session requires that the person respond to the therapist’s request to produce a work that addresses a specific task. At the same time, using the materials offered, she is challenged to complete the project in any way she wishes. She is in charge of managing the project – there is no control, but the need to engage her individual creative response to a problem. She is responsible for its completion and remains responsible, according to the permanent nature of art.

Some art therapists will provide complete freedom in an art therapy session… For those who are addictive, it may be too loose and too free. They would not be in treatment if they were not out of control. Therefore it is my feeling that it is more useful to provide set tasks, within which the client is free. This provides a balance: freedom within a form; I call it a safe haven. (pp. 27-28)

What appears to emerge from this discussion is the need for sensitivity on the part of the art therapist, and an acknowledgement of the potential for overwhelming the patient’s
fragile sense of self, either by the imposition of themes that are intrusive, or by leaving her floundering with no direction (Cooper et al., 2003). This of course highlights again the nature of eating issues, in which the negotiation of autonomy and control are paramount. Makin (2000, p. 42) also emphasises this point and states that:

The use of a combination of spontaneous art-making opportunities and specific directives presents individuals with opportunities to act out issues of control and/or lack of it, both on and off the page. (p. 46)

Cooper and Milton (2003) make a similar point, when they suggest that:

The key to successful practice lies in finding an art directive that addresses the unique element unifying the group in the present moment. That directive is then offered in such a way that it can be interpreted by each patient in any way she chooses. (p. 176)

On the issue of direction, Duncan et al (2004) state that:

Research indicates that clients prefer working with therapists who provide structure and a certain amount of direction in the therapy session. (p. 185)

Beresin, Gordon and Herzog (1989) had similar findings, in their research into clients’ perspectives of psychotherapy for women with bulimia. Their findings suggest that therapists need to walk a fine line between repeating the parental dynamic, by providing overly rigid structures (p. 115), and by providing inadequate direction. Their research found that “the patients uniformly reacted negatively to inexplicit goals, inactivity, silences, and formality (p. 114).

Interpretation and transference issues

There is less disagreement about whether to use interpretation with this client group, which is generally thought to be unhelpful, for similar reasons to those suggested in relation to the use of very specific directives. In other words, interpretation is seen as potentially overwhelming and may recreate the situation the client has experienced in the
family, of being “force fed” interpretations (Levens, 1987). It has been suggested that interpretation and transference issues may be expressed via the art work rather than verbally with these clients (Levens, 1987; Schaverien, 1989).

The dilemma for art therapists is that for many of them, their usual approach is via the use of interpretation and transference. The need to make interpretations almost seems to have been sublimated into the art therapy literature, which is full of interpretation, often without much substantiation.

Again we are reminded of Hogan’s (1997b) warning about rigid interpretations being more indicative of art therapists’ fantasies than of the client’s experience. This is also related to the client’s view of therapy in general, which is often different to that of the therapist. As Duncan et al (2004) suggest:

The hallowed act of interpretation, a direct offspring of the almighty model, nullifies therapy’s most valuable raw materials for change, the client’s own ideas and participation. (p. 185)

**Process vs. content**

Another area of debate in art therapy has been between the relative therapeutic value of working with the content, or art product, as opposed to the process of art making. Some art therapists have suggested the importance of working with the finished artwork with these clients (Makin, 2000; Murphy, 1984; Rabin, 2003; Schaverien, 1987, 1989, 1992, 1994a, 1995). Highlighting this approach, Makin (2000) summarises that “the explanation that many writers agree upon is that artwork acts as a buffer between therapist and patient” (p. 50). Makin makes a plea for “plain English” (Ibid) when commenting on the approach of Murphy and Schaverien, for example, arguing for greater clarity, and less use of jargon, from these art therapy authors. She contests that,
“although they both agree on the centrality of the art product, knowing how each gets to the key points may not be so easy” (Ibid).

Those who argue for the end product are usually emphasising the importance of having “a concrete way to mark changes and progress” (Makin, 2000, p. 50). This is a key aspect of Rabin’s (2003) approach, as she uses the repetition of tasks as a benchmark of change. Art therapists are also interested in the concept of externalisation (arguably both a process and a product), through which “art-making … can give concrete and observable form to psychic pain” (Cooper et al., 2003, p. 164).

Others such as Levens (1994b) and Mann (1990) have suggested that the exploration of the art-making process may be a more useful approach than purely focusing on the end product. The process may indeed be more important than has been cited in the literature, due to a tendency to focus on the finished art work as a product for interpretation. An argument in favour of the process, rather than the product, is that of seeing active participation as a key therapeutic factor of art therapy (Bruch, 1974; Cooper et al., 2003; Robertson, 1992). Cooper and Milton (2003) highlight the dynamics of the creativity process such that:

The capacity for creativity seems closely interwoven with the alchemy of the ego to bring order and meaning out of chaos and distress. (p. 164)

This creative process in the view of Cooper et al, takes the chaotic raw material of the psyche, and transforms it into something concrete and organized, namely the art product.

This latter point perhaps demonstrates in fact how closely interwoven the process and the product are. In her discussion of visual methodologies, Gillian Rose (2001, p. 202) has argued that both “sites” need to be considered, as does the third site, that of the audience, which in this case is the art therapist.
Dilemmas for art therapists: Summary

I have discussed a number of dilemmas for art therapists and we have seen that in working with women with eating issues, there is a need for art therapists to show greater flexibility in the following areas: the use of directive approaches; the use of alternative approaches to that of interpretation and transference; and the need to focus on the art-making process as well as the product. The lack of agreement on many of these issues may point to the fact that theory alone is not enough, but rather that as Hogan (1997b, p. 37) has suggested, more attention is paid to the client’s individual circumstances than to theoretical models.

3.4 Specified themes: Art therapy as “special recipes”

The following section revisits and critiques the approaches reviewed in chapter two, which looked at specific art therapy directives (from within the pro-directive camp) suggested for working with women with eating issues. The first section combines to include individual and group themes. Even in group art therapy, the self is cited as an important theme (Fleming, 1989).

Individual and group themes

One of the strongest meta-themes running through the art therapy literature is that of working on the self. Suggested directives which include: the self-box (Fleming, 1989; Rabin, 2003); the ideal self (Mitchell, 1980; Murphy, 1984); the self-image mandala (Rabin, 2003); “life size models of their ‘other selves’” (Murphy, 1984, p. 103); the self-world image (Luzzatto, 1994b); and the self portrait (Lubbers, 1991; Mitchell, 1980; Morenoff et al., 1989). It is clear that those art therapists who work directively see the
process of self-exploration through art as being the most important theme when working with clients with eating issues. The case studies and other narratives in which these themes are suggested, however, do not generally give an indication of how these activities proved beneficial to these women, or give first person accounts of how they were helpful (M. Wood, 1996). Recent exceptions include Rabin (2003) and Makin (2000), but these are in a small minority.

Body outline drawing is often cited as a means of addressing body image distortion (Fleming, 1989; Rabin, 2003; Woodhead et al., 1997). Other themes include family portraits (Fleming, 1989; Schaverien, 1995) and a feelings chart (Lubbers, 1991). Again, the clients do not give testimony as to the usefulness of these tasks. Their effectiveness as strategies is not demonstrated in the art therapy literature.

One exception, cited by Wood (1996) is that of Luzzatto (1994a; 1994b), whose “self-world image” technique led her to identify her formulation of the “double trap”, which she demonstrated to be effective in certain cases.

The most concerning aspect of these suggested themes is the lack of clients’ voices, particularly with reference to the exploration of the autonomous self. It could be seen that the use of non-directive work might be more suitable in this respect, in that it allows the clients to choose their own themes, but this has already proven to be problematic, as we have seen that these clients need a certain amount of structure in order to function (Makin, 2000; Rabin, 2003).

Val Huet (1997), an art therapist who usually prefers a non-directive approach to groups, states that “most clients with mental health problems would find the level of anxiety raised by such an approach quite intolerable and probably persecutory” (p. 128).

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10 See an example of body outline drawing from a fictional client’s perspective in Appendix J
Particular benefits of specific media: Art supplies as “special food”

As we have seen in the previous chapter, some art therapists have claimed that certain art media have particular benefits in working with women with eating issues. The media identified include clay, collage, mask-making and video. Before discussing each of these in turn, we will first consider Fleming’s (1989) use of the Expressive Therapies Continuum.

The expressive therapies continuum

Fleming (1989) describes the use of different media at different stages of art therapy groups, in accordance with the client’s developmental needs at that time. Fleming’s approach makes an interesting link to developmental stages, which does not appear to have been picked up by other writers. Fleming bases her model on object relations theory as it parallels the developmental stages of the expressive therapies continuum (Kagin et al., 1978). However, even disregarding object relations theory, and based on a purely pragmatic approach, it would seem that Fleming’s model has much to recommend it. Other writers have commented on the importance of being sensitive to the needs of the clients at differing stages of recovery (Hinz et al., 1990). Murphy (1984, p. 101) has argued that women with anorexia may be so afraid of losing control that they refuse to participate in art therapy.

It seems wise therefore to suggest the use of a variety of different media, and for the introduction of different media to be sensitively introduced, with a particular focus on the ‘controllability’ of the media concerned, which is one of the themes of the expressive therapies continuum. In other words, it may indeed be helpful to start by using art materials which are easier to control, and moving on to ‘messier’ and more fluid media.
when clients are able to do so, as Fleming has suggested (1989, pp. 283-285). The importance of offering a choice of art media should not be overlooked in this discussion, where the focus on *finding the appropriate media* may in fact be a very individual choice for each client, on any given occasion, for a whole variety of reasons.

*Clay*

The use of clay, by Robin Macks (1990) has been discussed in the previous chapter. Her writing is fairly typical of the art therapy literature, in that it uses an object relations framework and is based on interpretations within this framework. Macks’ hypothesis is that the use of clay is a powerful medium through which women can explore their early object relations. She is particularly interested in the notion of the clay and the female body as container. Her interest is such that it seems to override the evidence, citing the creation of box like shapes as a sign of “denial of the feminine” (p. 27) for example. These assumptions moreover are not validated by the voices of Macks’ clients.

Macks (1990) provides little evidence for the interpretations she makes on either the symbolism or effectiveness of clay work for women with eating issues, and although her ideas are interesting, they have not been substantiated.

Cooper and Milton (2003) describe the use of clay in a group of women with various acting out behaviours including eating issues. They suggest that:

> Clay can be experienced as a structured, solid building material as well as a mushy, regressive material, depending on the therapist’s presentation of the medium and the directives for its use. (p. 180)

Clearly clay may be used in a variety of ways according to the inclination of the art therapist. However this further implies that the method chosen may say more about the art therapist than it does about the client. The art therapy literature tends to focus on the
interpretation of the client’s experience, without reference to external factors such as the art therapist’s theoretical framework or orientation. This will be discussed further in chapter nine.

Collage

The use of collage has been suggested by a number of art therapists. Landgarten (1993) uses photos from a wide range of magazines to reflect the cultural and racial diversity of her clients. She has clearly given the matter of cultural and racial diversity a great deal of thought. It is surprising that she does not extend this awareness to gender issues, to explore the relationship between culturally produced images and the client’s internal world, particularly with regard to images of and by women. Rather, Landgarten (1993) suggests we use magazine images as an art medium, without a gender analysis of its dominant discourse.

It is of course arguable that the process of cutting and pasting such images always results in an alternative meaning from that originally intended (Weiser 1993). However, when faced with multiple images of slender young women and a dearth of ‘alternative’ images of women, it is difficult to see how the dominant paradigm could be challenged or subverted using this material, without some discussion of the ‘meanings’ inherent in the images with the women concerned. As Susan Bordo (2003) writes:

…images of slenderness are never “just pictures” as the fashion magazines continually maintain (disingenuously) in their own defence. Not only are the artfully arranged bodies in the ads and videos and fashion spreads powerful lessons in how to see (and evaluate) bodies, but also they offer fantasies of safety, self-containment, acceptance, immunity from pain and hurt. They speak to young people not just about how to be beautiful but about how to become what the dominant culture admires, how to be cool, how to “get it together”. To girls who have been abused they may speak of transcendence or armoring of too-vulnerable female flesh. For racial and ethnic groups whose bodies have been marked as foreign, earthy, and primitive, or considered unattractive by Anglo-Saxon norms,
they may cast the lure of assimilation, of becoming (metaphorically speaking) “white”. (pp. xxi-xxii)

Rust (1987) approaches this issue more critically, and includes an analysis of magazine imagery in relation to gender and body image. Her feminist approach, which is unusual in the art therapy literature, is discussed further in chapter five. Rust suggests that collage may be a very useful medium to use in order to examine the female stereotypes and the way these images affect women. Matto (1997, p. 351) makes a similar point, arguing that collage based on magazine images can link into discussions about internalised messages which can then be examined as cognitive distortions.

Commenting specifically on the use of words in collage rather than images, Wood (2000) has argued that collage may be used in a defensive manner which she describes as the ‘anorexic defence’ (p. 175).

**Mask-making and video**

Murphy (1984, p. 103) mentions the use of mask-making and video, in reference to an unpublished Goldsmiths study, but does not describe the nuts and bolts of the exercise, or evaluate how successful it was. Similarly, Matto (1997, pp. 351-352) describes the use of mask-making as a way to externalise the ‘false self’, and Cooper et al. (2003, pp. 187-188) give a case example of a woman, ‘Jo’, who used mask-making to externalise her emotional pain. Cooper et al, unusually, include a quote from Jo in their vignette.

The use of video, in combination with mask-making, was found by Hinz and Ragsdell (1990, p. 260) to be detrimental in their art therapy group, as it caused a dramatic drop in participation levels. The authors’ intention, like Matto (1997), was to use mask-making and video to explore concepts related to the participants’ true and false selves, but
apparently did not take into account whether the participants were ready for such an activity at that time, since the majority found it too threatening.

Clearly the use of masks has some potential benefits if we accept the construct of the true and false self, or if we utilise masks to explore and externalise other aspects of the self that are in conflict, from a cognitive perspective for example. However this has not been researched or evaluated.

Discussion

Given the fact that all the art therapists identify different media, we have to conclude that this is sometimes a matter of personal preference rather than of proven effectiveness of specific materials. Macks (1990) for example acknowledges that she chose to use clay with her clients as she had experienced its unique properties for herself:

I knew that for me, claywork had been a centering and grounding activity during a difficult time in my life. It had been a way for me to return to an inner place and connect with a deeper self. (p. 22)

A more general observation would be that there is much difference of opinion on the matter of media choices, and that it is mostly opinion. Not much, again, is backed up by research or clients’ voices. Possibly these matters are not as critical as we think they are, as it is the relationship which matters more to the client (Duncan et al., 2004). All varieties of art materials, moreover, provide opportunities for active participation in the creative process. The factors which determine which medium best suits a particular client, at a particular moment in time, may be entirely random, or idiosyncratic. Perhaps, in our search for the magic ingredients of art therapy, we are mirroring the anorexic’s parent, trying to find the “perfect food” for our recalcitrant, starving child/client.
The second half of this chapter is devoted to further exploration of issues “missing” in the art therapy literature.

### 3.5 What is missing in the art therapy literature?

The following section will examine the gaps in the art therapy literature, and explore the issues which have so far not been addressed by art therapists, in working with women with eating issues.

**Client’s voices: An ominous silence**

In common with a great deal of art therapy literature in general, the voices of the women, who have used art therapy in their struggle to make sense of their eating difficulties, have been given very little space. Authors who have included women’s voices are Rabin (2003), and Makin (2000). The fact that these are more recent publications may point to a new awareness of the need to consider this ‘alternative’ voice in art therapy narratives.

The majority of art therapy literature is strongly biased towards the viewpoint of the therapist rather than the client. For me this imbalance does not sit well, particularly in regard to the dynamics of eating issues, which are strongly related to issues of power and control.

In their latest book *The heroic client*, Duncan, Miller and Sparks (2004) argue that therapists do not generally pay enough attention to their clients’ strengths and resources, “which account for between 40 and 87 percent (depending on the analysis used) of change” (p. 51). This research suggests that therapists need to “spend our time more wisely gaining experience on ways to employ the client in the process of change” (p. 51).
One way to do this is to start taking note of “clients’ perspectives regarding therapy and the therapist…(rather than consigning them to) the cutting room floor” (p. 63). Specific suggestions for therapist’s behaviour from Duncan et al are as follows:

- Being likeable, friendly and responsive.
- Carefully monitoring the client’s reaction to comments, explanations, interpretations, questions, and suggestions.
- Being flexible: doing whatever it takes to engage the client…
- Validating the client. Legitimising the client’s concerns and highlighting the importance of the client’s struggle. (Duncan et al., 2004, p. 65)

Besides the need to listen carefully to the client, Duncan et al argue for a more flexible approach to therapy. This suggests that the object relations model (or indeed, any model) as a single approach may not meet the needs of all clients. It challenges art therapists to do different things, and specifically try different approaches, in their therapeutic practice.

In my view the lack of research into the effectiveness of art therapy is tied in with the lack of client’s voices, since it is the client who may have the best sense of whether a form of therapy they had participated in had been effective for them. This is another factor that was influential in my research design, which I have attempted to address in my clinical work, and in this thesis.

*Focus on anorexia as subject: Art therapists filling the void?*

In the art therapy literature I surveyed, out of fifty six articles which mentioned art therapy as treatment for eating issues: thirty six focused on anorexia; sixteen focused on bulimia; three mentioned compulsive eating and only one mentioned obesity. Sixteen focused on a combination of eating issues, usually anorexia and bulimia, and some were therefore counted twice. Thus the ratio of anorexia compared to other eating issues/eating issues in general in the art therapy literature is approximately 2:1. The
earlier articles in particular (1980-87) did not usually mention bulimia, although accounts of binge eating and self-induced vomiting behaviours in the medical literature had already increased by 250% in the 1960’s (Agras & Kirkley, 1986p. 368), and the term “bulimia nervosa” was coined in 1979 (Russell, 1979).

Generally speaking, far greater interest is shown in anorexia than in other eating issues (McNulty, 1998). This is reflected in the popular media, such as women’s magazines, as well as in the clinical literature. Clearly, women with anorexia are often more seriously ill, and therefore more likely to be hospitalised. They are also less likely to be treated in a community setting. This may be one reason for their predominance in the clinical literature, which usually focuses on medical settings.

McNulty (1998) suggests an alternative interpretation for the Western society’s pervasive fascination with anorexia. She argues that we are more interested culturally in women’s deficits than in their desires:

Anorexia is possibly discussed more because the name confirms, rather than contradicts, the construction of women as lacking. Bulimia and bingeing name women’s desire, even if it is difficult for a woman to respond appropriately to what she wants. The issue of the naming of “eating disorders” should remain on the feminist agenda, to sustain interest, not only in the problem (how women use food in different ways and the material effects on their lives) but also in why it has developed and what might be done to effect change. (p. 23)

The emphasis on anorexia in the art therapy literature is problematic since it focuses our attention on the most extreme form of eating distress. This has the effect of de-emphasising the concept of a continuum of eating issues as suggested by Brown (1993), which as we will see in the following chapter is one of the key elements of a feminist perspective on eating issues.
Demonstrated efficacy

In my literature search, I did not find much ‘evidence’ to convince me that art therapy was proven to be effective in the treatment of eating issues, despite the various authors’ assertions that it was. Hinz and Ragsdell (1990) for example, [citing, Wooley and Kearney Cooke (1986), Levens (1987) and Schaverien (1989)], claim that “art therapy has been demonstrated to be therapeutically effective with eating disordered clients” (p. 259), without justifying this statement with clinical evidence. This point is raised by Wood (1996), who suggests that:

…writers have tended to concentrate on describing why art therapy may be effective rather than on evaluating whether it really is. (p. 18)

Wood (1996) identifies a lack of research into the effectiveness of art therapy with eating disorders. She is unable to discover much evidence in the British art therapy literature that art therapy is particularly beneficial in the treatment of eating disorders\(^1\). She cites Luzzatto (1994b) as the only art therapist of those surveyed who claims that “art therapy sessions were the main agent for therapeutic change and that this change was maintained” (p. 18). Wood concludes however that despite the lack of substantial evidence so far:

The recognition of the power in the combination of non-verbal and verbal elements as an appropriate possible means for engaging with people whose distress is contained within their bodies, gives art therapists sound starting lines from which to evaluate and develop practice with this challenging and difficult client group. (M. Wood, 1996, p. 19)

Since Wood’s (1996) article, Rabin (2003) has published her study of art with women with eating issues through the device of repeated art therapy tasks over a period of time. Rabin (2003) states her hope for the future, namely: “I envision expressive art being accepted as reliable scientific evidence in its own right” (p. 149).

\(^{1}\) Hogan (1997b) refers to some art therapy case studies as ‘seductive fiction which poses as ‘scientific’ writing…they are particularly alluring since they claim to tell what is really going on in the client’s mind and art work…such fictions are completely abstract and remote when seen in the context of people’s lives” (p. 40).
Spirituality

Maclagan (1998) argues that it is a mistake to treat the anorexic at the concrete level at which she operates. He argues against a purely psychoanalytic approach, which he sees as confining and misleading, stressing instead the “need to recognise the imaginal or soul dimensions behind even the most alarming reality” (p. 90). This is achieved, according to Maclagan, through the pathway back via aesthetics to the archetypal or “soul” dimension of art therapy (p. 80). The issue of spirituality, which draws on a Jungian approach to art therapy, is one that was not addressed in the literature, apart from in Maclagan’s article.

The treatment milieu

Between the microcosm of therapy and the macrocosm of culture, lies the treatment milieu. This “context of therapy” as Wood (1996) refers to it, is identified as a relatively unexplored area in the art therapy literature. According to Wood, the context of therapy should include factors “such as the institutional setting…the persona, body and gender of the therapist, and the effects of work done by other members…of the team” (my italics) (M. Wood, 1996, p. 18). These factors will now be considered in turn, with a focus on ‘gaps’ or absences in the art therapy literature.

The institutional setting

Wood (1996) suggests that the impact of the therapeutic environment on art therapy practice has not been given enough consideration to date (p. 18). Much of the art therapy literature describes hospital based rather than outpatient or community based treatment. Art therapists, moreover, have not frequently discussed to date the advantages and disadvantages of working within medically based institutions, compared to community
settings. Given that clients often express about their strong dislike of being in hospital (Ronen & Ayelet, 2001, p. 117), this would seem to be an important area to include both in describing and researching art therapy practice.

In terms of exploring the institutional setting and its effect on outcomes, this raises the question of how to research the effectiveness of art therapy in isolation. It seems clear that in order to demonstrate the effectiveness of art therapy, particularly in the in-patient treatment of eating disorders, other treatment modalities would also need to be included in the research. Conversely, this also suggests perhaps that research conducted in outpatient or community settings may give a clearer picture of the value of art therapy as a discrete approach.

In her description of an innovative, integrated approach, Holly Matto (1997) argues against the narrow focus on the psychodynamic, hospital-based orientation of much of the art therapy literature, which, in her view:

…does not seem to focus significant attention on the importance of the client’s involvement within the community as an integral part of the recovery process. (p. 347)

In order to redress this perceived imbalance, Matto proposes an integrated model, which combines the hospital based ‘medical’ approach with community involvement.

The persona, body and gender of the art therapist

Wood (1996) identifies three aspects of the art therapist herself that the British art therapy literature has not explored, namely the “persona, body and gender of the therapist” (p.

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12 “My drawings during those long, unending days in the youth psychiatric department illustrate my belief in an external force that made decisions for me” by Ayelet in The story of the client, the therapist and the process of recovery (Ronen et al., 2001, p. 117).
18). Clearly the art therapist is a contributing part of the treatment milieu, both in terms of her personal presence and in her theoretical approach.

The *persona* of the art therapist, which is not clearly defined by Wood (1996), suggests the individual style and stance adopted by the therapist, and how this impacts on the client. This could include her manner, for example in terms of openness, friendliness, and level of self-disclosure, level of participation, as well as her dress, general appearance and body language.

The object relations approach, which underpins a great deal of art therapy theory and practice, does not place a great deal of emphasis on the therapist’s personality, apart from her need to be ‘good enough’ and to have the capacity for holding and containment. In psychoanalytic terms, the therapist has traditionally been required to act as a “blank screen”, in order for transference to develop more freely (Storr, 1979, p. 63). Perhaps because of this, the persona of the art therapist has not often been examined. In other words, her personality is meant to be obscured rather than revealed. This stance has meant that the personality of the therapist has not been widely acknowledged and been a matter of reflection. Even more problematic, it has been regarded as neutral or at most a benign presence. This may not be the client’s experience, but this has not been discussed with the client. Paul Gibney (1995), in an interview in *Psychotherapy in Australia*, argues that the blank screen approach:

…comes from a belief in forming a transference neurosis and that is by no means the only way of working. The danger of working that way is its more about keeping the therapist safe than it is about facilitating the client’s process. (p. 36)
The body of the art therapist has mainly been discussed in the literature in relation to her pregnancy and the resulting change in shape (Skaife, 1998; ter Maat & Vandersyde, 1995; M. Wood, 2000). The usual (non-pregnant) body size of the therapist, and her level of satisfaction with her size, is not generally mentioned\textsuperscript{13}. Wood (2000) suggests that many clients with eating issues would be “acutely aware of the therapist’s body” (p. 18). Indeed Kearney-Cooke (1989) argues that a feature of the eating issue may be to unfavourably compare oneself to other women (pp. 22-23). Given that, according to Kearney-Cooke, her mother’s body image seems to have a bearing on the client’s own body image perception (p. 14), the body image of the therapist, via the process of transference, seems also likely to be significant in the client’s recovery.

The gender of the art therapist is similarly rarely discussed, which is perhaps surprising given both the prevalence of female art therapists (Joyce, 1997) and the prevalence of females with eating issues (Dolan & Gitzinger, 1994). This may be related to Susan Joyce’s (1997) notes the absence of a feminist voice in art therapy, with some recent exceptions (Hogan, 1997a; Waldman, 1999). It can be speculated that the ‘avoidance’ of addressing these issues in art therapy with women with eating issues, is related to the avoidance of discussion of gender issues in art therapy in general. Joyce (1997) has argued that medical hierarchies have played a part in privileging ‘male’ knowledge and expertise, as represented by psychiatry and psychology, and disadvantaging ‘female’ knowledge and expertise, as represented by nurses and creative therapists (p. 82). Gender issues will be discussed at greater length in the following chapter, which seeks to identify “alternative” frameworks for working with eating issues.

\textsuperscript{13} An exception is Rosal et al (1998) in their chapter on art therapy with obese teens:

All three leaders were of average to below average weight. The differences were noted and the leaders discussed these issues, which had the potential to be obstacles in the group. (p. 118)
A multi-disciplinary approach

Various authors including Wood (1996), have suggested that art therapy treatment alone is not sufficient in addressing the complex problem of anorexia, but that it needs to be part of a multi-disciplinary approach (Levens, 1987; Lubbers, 1991; Murphy, 1984; M. Wood, 1996). McDermott et al. (2002) for example, recommend a collaborative approach, so that:

…weight monitoring be a central feature of any individual therapy for anorexia nervosa, and therapists are further advised to establish professional relationships with interested paediatricians or general physicians”. (p. 324)

In particular, the inpatient treatment of women with eating issues is likely to involve a variety of interventions from various disciplines, such as: psychiatry, dietetics, nursing, social work, psychology and occupational therapy, in addition to art therapy. The patient may also be offered family therapy if she is an adolescent. This raises the question of how individual treatment interventions can be considered, either formally or informally, without reference to the wider spectrum of treatment. Claims made for the efficacy of art therapy often do not take these complex factors of a multi-disciplinary approach into consideration.

Alternative theoretical frameworks

As previously discussed, the majority of art therapists base their approach on psychodynamic object relations theory. Apart from Matto’s paper, (1997) in which she describes combining art therapy with narrative and cognitive behavioural therapy (CBT), and Rosal et al. (1998), who combined art therapy with psychoeducation, there is not much consideration of art therapy approaches other than those based on psychodynamic theory. “Alternative” approaches, some of which are further discussed in the following

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14 Rosal (1998) argued that the use of psychoeducation was not beneficial in their group for obese teens (p. 129).
chapter, could include for example: Gestalt therapy; cognitive behavioural therapy; family therapy; solution-focused; strengths-based and feminist therapy approaches, which, Hyland Moon (2002) argues, have developed, partly due to the influence of post-modernism on psychotherapy, over the past thirty years.

Bruch (1978), commenting on previous treatment her patients with eating issues have reported, states that adherence to the psychoanalytic model may even be harmful:

Many therapists in approaching an anorexic patient are tied to outmoded concepts of psychoanalytic treatment, even those who otherwise work with contemporary concepts. Many stress the symbolic meaning of the noneating and the underlying unconscious problems, fantasies, and dreams, and interpret their unconscious meaning to the patient….one can recognise that for these patients it may signify the reenactment of some damaging experience in their past. (pp. 122-3)

In contrast to the psychoanalytic approach, Bruch (1978, pp. 126-127) suggests that offering hope, stressing universality and giving information are key factors in treating these patients.

In addition, and again with the exception of Matto (1997), the art therapy literature does not offer a critique of theoretical approaches to eating issues which underpin treatment by other professional groups (such as the biomedical approach, or the feminist approach, both of which are well documented), which would put the psychodynamic art therapy perspective into sharper focus. There is in particular little discussion of the interface between art therapy and the medical model, which dominates treatment of eating issues, and which defines the treatment milieu within which many art therapists work.

The process of adolescent development

Anorexia is primarily a problem of adolescence (Crisp, 1980). There are a number of factors that point to such a conclusion. The majority of cases of anorexia first occur in adolescence, with “the mean age of onset being 17 years” (McDermott et al., 2002, p. 106).
Since most authors accept the notion of the “search for identity as the key issue” of adolescence (Riley, 1999) there appears to be a strong thematic link between adolescence, anorexia, and identity issues. Crisp (1980) describes anorexia as an attempted solution to a maturational crisis, or “the most primitive of avoidance responses to the immediate problems of adolescence” (Crisp, 1980, p. v). Jessner and Abse (1960), similarly, write that:

Anorexia nervosa, with its hysterical, phobic, obsessive, psychosomatic and psychotic features and suicidal tendencies, seems to condense the potential pathology of adolescence. (p. 302)

Surprisingly little has been written by art therapists about the developmental aspects of eating issues. This omission may be related to the predominance of the object relations framework. This framework takes a developmental approach, but is more concerned with early infancy than with adolescence. The stages it identifies are: - omnipotence, splitting and separation/individuation (also referred to as the depressive position). In a sense these stages are renegotiated in the adolescent period which, as stated earlier, is concerned with the development of the self as an individual autonomous being separate from the parents/family, with one’s own sense of identity.

If we consider the notion that adolescence is a period in which identity issues, including sexual identity issues emerge, it makes sense to see these clients’ difficulties in leaving their families and moving out into the world, for a variety of reasons, as adolescent themes. Blos (1962, pp. 12-14), for example, identified the following main areas of adolescent development:

1. The adolescent moves from concrete to abstract thinking.
2. Judgment and logical thinking are developed.
3. Social skills, empathy, altruistic and sexualised feelings become stable.
4. Self-image has become firm enough to withstand criticism and stress.
5. A sense of identity incorporates successfully a variety of internal and external roles.
6. Comfort with a changed body image frees the youth from obsessing about appearance.
7. A sense of self strong enough to continue to mature with reduced outside assurance.

Virtually all Blos’ areas can be applied to women with eating issues, suggesting that an adolescent developmental framework can be useful in their treatment.

The theme of adolescent rebelliousness, for example, is not often mentioned in the art therapy literature, even though refusal to eat can be seen as a hugely rebellious act (as for example in the case of political hunger strikers) and can often be understood in these terms, when an individual has no other way of being heard (Orbach, 1986).

An additional factor which has largely been omitted in the literature on art therapy and eating issues is that of peer influence. One could hypothesise that the lack of focus on adolescence in the literature has resulted in the omission of this important factor of peer pressure, since arguably it is during adolescence that peer factors play a more significant role that at any other stage of development.

*Gender analysis*

As we have discussed, Michele Wood (1996) notes in her literature survey, that there is little discussion of “the persona, body and gender of the therapist” in the British art therapy literature (p. 18). Even more surprising, perhaps, the gender of the patient as a specific factor is also rarely discussed. Given both the prevalence of women within the clinical population, and the prevalence of body image dissatisfaction within the general female population, this is clearly an area that may benefit from further exploration.

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15 For example, Waller, Hamilton and Shaw’s (1992) study on the effect of media images on the body size estimation of both eating disordered and “normal” women, found that the images’ effects “were stronger in those with more pathological eating attitudes in the comparison (non-clinical) group” (p. 81). However, clearly the images had an effect on both clinical and non-clinical groups, with the difference being one of degree.
According to Wood, the socio-cultural environment with particular regard to gender, has not generally been incorporated into an art therapy approach.

Wood (1996) cites two authors, Diane Waller (1994) and Rust (1992, 1994), who examine cultural and social expectations of women’s bodies, and the effect of this on their eating behaviours. Waller has a clear interest in socio-cultural issues, as evidenced both by her exploration of non-Western social eating behaviours (Waller, 1994) and of her interest in group approaches (Waller 1993). Waller however does not expand on this theme in her writing, but focuses on the non-Western cultural milieu. Rust’s work with women with eating issues, which, unusually, includes a feminist approach, is discussed further in chapter four.

American art therapist Robin Macks (1990) explores gender issues in her work with women with eating issues. She suggests that:

> The eating disorder client is a woman who lives in a patriarchal culture that does not value, much less worship, the woman. She ascribes to this culture’s values, pursues thinness, and does not value the feminine. (p. 23)

Macks (1990) uses the symbolism of claywork to argue for its benefits, describing clay as an “earth-derived mother symbol, a creation symbol” (p. 28) and the (clay) vessel as “an ancient symbol for the feminine” (p. 28). She expresses the hope that:

> By using clay...to create a vessel, the client may begin to repair mother-introjected anti-feminine messages. The occurrence of the box as the container of choice for so many of my clients has demonstrated the severity of their disability to internalise a nurturing mother...perhaps with long-term treatment, these women could gradually...begin to move toward rounder forms and an acceptance of their womanliness. (p. 28-29)

It is interesting to examine Macks’ statement above in more detail. She seems to be arguing for women to accept their own body shape, as evidenced by the “move towards rounder forms” in the quotation cited above. This argument is however based upon her premise, firstly that the clay vessel symbolically represents the female body, and
secondly that, by striving for thinness, women with eating issues are unconsciously rejecting their femininity. She does not however offer direct evidence of these meanings being relevant or “real” to her clients.

Macks (1990) makes some interesting links between clay and vessel symbolism and gender issues. Unlike many authors, Macks does not cite case examples, but is intent on making general observations. Her interpretations of the art work produced, and the art therapy process, seem to be based upon a combination of psychoanalytic theories, incorporating both object relations and Jungian frameworks. She also draws on her own personal experience using clay (p. 22). It is disappointing that she does not include information on whether individual women she worked with benefited from claywork therapy, although she implies that the short-term nature of her work was a limitation (p. 29). Equally, Macks does not discuss the need to challenge social and cultural values placed upon women’s bodies, in order to remove some of the pressures placed upon women to be thin.

The issues related to gender will be discussed at greater length in the following chapter, which will seek to identify ‘alternative’ frameworks for working with eating issues beyond the existing art therapy arena.

*Cultural attitudes towards body image, eating and food*

Issues about food and eating are not generally discussed in the art therapy literature. Diane Waller (1994) is one exception who writes about the Balkan’s rather than our own Western culture.

Rosal et al (1998) write about art therapy with obese teens, and include consideration of racial and cultural factors, for example finding that “the African American teens were much more comfortable with their weight than were the Caucasian teens” (p. 114), thus
confirming the research by Desmond, Price, Hallinan and Smith (1989) who “theorised that being overweight in the black culture is more acceptable and not as stigmatising as in the white culture” (Rosal et al., 1998, p. 114).

In both these examples, it appears that art therapists are more comfortable writing about the “other” than about their own culture, which is not explored in any systematic way. In a sense, the examination of body-image in non-Western or non-Caucasian culture does indeed, if somewhat obliquely, throw light on Western culture. In looking at ethnicity, for example, Striegel–Moore and Smolak (1996), like Rosal et al. (1998), found that in the United States:

> Black women’s “gender roles, compared to those of white women, seem less shaped by an emphasis on outward appearance and more determined by pride in self and community” (Striegel-Moore et al., 1996). Wider social support networks, therefore, may offer protection against low self-esteem and poor body image. (Morgan, 2000, p. 20)

Alternatively, non-identification with the dominant white Western culture, rather than different support structures, may be the key protective factor here, and this may change over time:

> In one study of Kenyan immigrants to Britain, it was found that Kenyan women tended to rate larger female figures more favourably than Caucasian British women, while Kenyan British women who had been in the UK for at least four years, were more similar to the Caucasian British women in their perceptions of body size. (Morgan, 2000, p. 20-21)

This transition towards Western culture, and the consequent change in self-appraisal in women from developing countries, echoes the phenomenon reported by Duguid (2004), who describes how “once unknown in South Africa, cases of anorexia among black women there have soared since the end of apartheid” (p. 20) and that “…in cities, where Western culture has taken hold, black women, like white women, always want to be slimmer” (Ibid). Bordo (2003) argues that whereas anorexia used to be seen as a “white” issue, this is changing: “the profile of girls with eating problems is dynamic, not static; heterogeneous, not uniform” (p. xx). She makes the point that from the perspective of a
black woman with anorexia, the coding of anorexia as a “white girl’s thing” can be “almost as oppressive as her eating disorder” (Ibid).

Thompson (1992) makes a similar point, arguing that the issue is often one of cultural perceptions and racial stereotypes. She found in her multi-racial phenomenological study in the United States, that:

…according to the normative epidemiological portrait, eating problems are largely a white, middle-class phenomenon…there has been almost no attention to how other systems of oppression may also be implicated in the development of eating problems. (p. 546)

According to Thompson, experiences of “sexual abuse, racism, classism, sexism, heterosexism, and poverty” (Thompson, 1992, p. 547), can all have a causative effect on the development of eating issues.

On the issue of sexual orientation, a study by Brand et al, (Brand, Rothblum, & Solomon, 1992) found that “gender was a more salient factor than sexual orientation on most variables…both lesbians and heterosexual women are influenced by cultural pressures to be thin, but…these pressures may be greater for heterosexual women” (p. 253).

What is not in dispute, is the predominance of women as opposed to men who develop eating disorders at a ration of about nine: one (Bordo, 2003, p. 140). In an Australian study (Maude, Paxton, Gibbons, & Szmukler, 1993) the authors found that female adolescents “indicated greater body image disturbance than males” (p. 131) with “nearly half the girls…using an extreme weight loss method at least occasionally”. In addition, the authors found that:

A substantial percentage of girls who fell within the normal weight range classified themselves as overweight and nearly half of those in the underweight range considered themselves a good weight…for subjects of both sexes, those with higher BMI’s were most likely to report body dissatisfaction. (p. 131)
In her survey of American college students, Steiner-Adair (1989) compared young women’s relative identification with current cultural expectations for women and correlated these with bulimic behaviours. She found that for these women:

…the failure to identify prevailing cultural expectations of independence and success and to differentiate these expectations from their own values of care and connection may lead them to act out a conflict between these different values in self-destructive patterns of eating behaviour. (p. 151)

Thus one can clearly hypothesise that there is a strong link between Western culture, eating issues and negative body image in women, and increased incidence of eating disorders is likely to correlate with this association. Susie Orbach (1982; 1986; 1994) has written extensively on this topic from a feminist object relations perspective. Art therapists, however, have been strangely silent on this topic.

3.6 Summary of chapter three

This chapter has taken a critical look at the art therapy treatment of women with eating issues, and has identified a number of gaps in the literature, particularly in the lack of consideration of socio-cultural issues, and the under-representation of clients’ voices. This critique of the literature repeatedly highlights the fact that art therapists have not provided clients with opportunities to “speak”, and their treatment strategies frequently have not been evaluated. The wider view of the therapeutic milieu, and the socio-cultural environment, has not been examined. However, some potentially encouraging areas have been identified. For example: the suggestion that the active quality of art therapy participation may of itself be therapeutic; the relationship between the materiality of art supplies and food; the externalisation of internal experiences; the visual quality of art therapy/eating issues; and the importance of group work.

Factors which art therapists need to pay more attention to have also been suggested, including: the importance of the art-making process; the process of adolescent
development; the need to provide a range of art media; the need for flexibility in approach; the need for alternatives to the object relations model; and the prime importance of the therapeutic relationship. The following chapter will explore alternative, (i.e. non-art therapy approaches) informed by feminist psychotherapeutic practice, which will then be utilised to develop a more inclusive framework for art therapy with this population.
Chapter four: Alternative approaches to women with eating issues, informed by feminist therapeutic practice

All therapies are informed by a political perspective. (Eichenbaum et al., 1983, p. 69)

The previous chapter provided a critique of current art therapy approaches to women with eating issues. This chapter explores alternative therapeutic frameworks, which have been utilised with this client population. In particular I am interested in discovering approaches, which assist us in placing women in a social context and in giving them a voice. Feminist theory and therapeutic practice may be valuable in offering an understanding of the relationship between individual women and the culture they live in. To date the art therapy literature, as I have shown in the previous two chapters, has not often attempted to develop the relationship, between the microcosm of therapy and the macrocosm of Western culture. Yet as I have argued, this relationship or interplay may be crucial in our understanding of art therapy as it applies to women with eating issues.

In order to provide a theoretical foundation for this exploration, and to seek useful links with relevant disciplines, I shall consider the following:- a definition of feminist theory; an exploration of feminist theory in relation to psychoanalysis; feminist critiques of the biomedical and psychoanalytic models of treatment; definitions of feminist therapy; and feminist approaches to eating issues. The following chapter (chapter five) will address the implications of these alternative frameworks on art therapy practice, which forms the foundation of an alternative approach.
4.1 Feminist theory

What then do we mean by the term “feminist theory”? Worel and Worel (1992) define feminism as both a concept which advocates for the rights of women, and a political movement which tries to achieve them. In trying to define feminism, various authors (Beasley, 1999, p. 43; Worel et al., 1992, p. 14) note that it is a broad term with many different interpretations and variations. In popular culture, feminism may be mistakenly understood as being ‘anti-men’ rather than ‘pro-women’s rights’. Before considering the various kinds of feminism, Beasley (1999, p. xv) attempts to define feminism as a whole, both as a critical stance on the dominant culture, and as a “positive terrain” with specific characteristics and values.

Feminist theory as critique of existing material

If we look at its function, for example in literacy criticism or cultural theory, one of the ways we can define feminist theory, Beasley (1999, p. 11) suggests, is in its critical function, namely that of deconstructing mainstream Western thought. For example, feminist theory seeks “hidden meanings” within texts and images, which relate to power and oppression\(^{16}\). As Beasley indicates, feminist theory is often understood intellectually as a reaction to pre-existing, “traditional” material rather than a theory in its own right, with positive connotations:

It is possible to conceive of feminism as simply a critical strategy/stance which is concerned with particular contexts and is short-term in orientation, rather than as the fully-fledged world-view or doctrine described by dictionaries. (Beasley, 1999, p. 28)

\(^{16}\) This immediately suggests a parallel with psychoanalysis, which seeks unconscious meanings, hidden in words and images.
**Feminist theory as a “positive terrain”**

Beasley (1999, p. 29) challenges this understanding of feminism as a “critical stance” whilst stating that it is still useful since it “implies an imperative towards change”. She attempts to do this by “marking out both the dimensions and content of a positive terrain” (Ibid., p. xv). She acknowledges this approach is more pragmatically than theoretically oriented. This pragmatism, she argues, “allows for diversity and change” (Ibid., p. xv). It may also prove more useful in the *practical application* of feminist theory, as for example in feminist (art) therapy.

What then are the positive attributes of feminism? The core elements identified by Beasley (1999) include:

- A critique of misogyny/sexual hierarchy;
- A focus on women as the subject of analysis;
- An expansion of what may traditionally be discussed;
- Diverse perspectives;
- A challenge to sexual hierarchy;
- Collectivism; and
- Relevance to women in particular (see Beasley, 1999, p. 36).

I would suggest that many of these core elements identified by Beasley may be helpful in developing an alternative model of art therapy practice. This will be explored further in the following chapter. Beasley also emphasizes the fact that women’s experiences, and therefore women’s voices, are privileged in feminist theory. She states moreover that:

> It would seem that more recently feminism has been defined not simply as a particular framework set of ideas or social analysis or form of critical questioning around a focus on women and power, but also as representing a **specific body of experience**. This body of experience is taken to refer to the impact of *being* female, *having a female body* in Western society (Beasley, 1999, p. 33).

Again, the relevance of this “embodied” aspect of feminism is clear in the treatment of women with eating issues.
Within feminist theory, a large number of conceptualizations of the field exist – many are defined by the type of social theory they embrace, others focus on a particular issue (such as race) as it impacts upon women. Beasley (1999, p. 43) identifies seven major conceptualizations of the field: liberal; radical; and Marxist/socialist feminism; Freudian; Lacanian (including the “écriture féminine” school); postmodernist/poststructuralist; and, feminism that focuses upon race/ethnicity.

**Feminist theory derived from psychoanalysis**

I shall briefly consider two of these feminisms in particular, namely Freudian and Lacanian feminism, since they are both derived from psychoanalysis, and thus have a particular relevance to psychotherapy. These feminisms may have something to offer a feminist view of art therapy, in that they seek to create and enable creative forms, and to value the feminine, nurturing role.

**The “écriture féminine” school**

The French “écriture féminine” school develops Lacanian psychoanalytic theory by constructing “a rebellious cultural creativity” (Beasley, 1999, p. 72) as an alternative language to that representing the masculine/phallic Symbolic Order which dominates Western culture. This school focuses mainly on poetry and writing as a form of creative expression. It is closely related to the theories of post-structuralist Jacques Derrida (1988), who has developed concepts in critical theory and the deconstruction of the Symbolic Order, or the “unpacking of the cultural/linguistic assumptions regarding the fixity and inevitability of forms of power with the aim of opening up alternative possibilities” (Beasley, 1999, p. 74). This could have practical expression in the challenging of diagnostic labeling, for example in the treatment of eating issues.
Whilst this school focuses mainly on language, it seems to have application in the aesthetic sphere, in developing an alternative feminist aesthetic, for example. It also has implications for psychotherapy, since it suggests that existing power dynamics can be challenged through the use of language.

_Feminist theory and Freudian psychoanalysis_

The American psychoanalytic feminist school similarly challenges the traditional Freudian approach and constructs an alternative view. Beasley (1999) defines Freudian feminists such as Nancy Chodorow by their interest in the role of the mother (rather than the father) in “the formation of (sexed) identities” (p. 66), thus moving away from Freud’s concept of penis envy, to a stance which values the influence of mothers “as positively contributing an alternative psychological order” (p. 67). Chodorow for example “stresses the advantages of men becoming more like women in terms of developing nurturing, empathetic characteristics” (Beasley, 1999, p. 68).

By briefly considering the French Lacanian school, and the American psychoanalytic feminist school, we can glimpse already some the positive traits that feminist thinking can contribute. The following section looks at definitions of feminist therapy, which seeks to apply feminist theory to the practical arena of psychotherapy.

_4.2 Feminist therapy_

Women seeking to understand ourselves, illuminate not only ourselves but the forces for growth that patriarchal society has kept undeveloped and hidden from all. (Baker Miller, 1983, p. 9)
We shall now consider what makes feminist therapy different from more “traditional” forms of psychotherapy. A brief look at the history of feminist therapy may assist us in understanding this difference. Much of feminist therapy has grown from the experiences of women in both “traditional” psychoanalytic groups and in consciousness-raising (C-R) groups (Brodsky, 1973; Eichenbaum et al., 1983).

C-R groups arose in the nineteen sixties and seventies as self-help and support groups for women, which encouraged sharing of experiences within a safe and supportive framework, without the need for “expert” therapists. They arose as part of the wave of social change occurring at that time, and partly as a response to concerns about the negative effects on women of traditional forms of psychotherapy. Sandra Butler (1983), an American writer and counsellor, writes about her participation in such a group in the nineteen seventies, with evident excitement:

> It was the beginning of a new way to think about healing and nurturing. It was the creation of a new form and it was the genesis of my becoming whole. We struck the most delicate balance between demanding and insisting on the fullest and finest from each of us, and carefully and painstakingly helping each other move through our terrors and feelings of inadequacy. We were re-thinking what it meant to be fully alive. Fully human. A woman. And I was never the same again. (Butler, 1983, p. 109)

Arguing that women have often benefited more from participation in C-R groups than traditional psychotherapy groups, and proposing a model for feminist therapy, Brodsky (1973) offers the following recommendations for feminist therapists:

> Be aware of the increasing diversity of women’s roles, and of the reality of the client’s situation; offer encouragement; promote independence (including from the therapist); offer support and belief in her competence and ability; recognise the need for social activism.\(^{17}\) (see Brodsky, 1973, p. 27)

Brodsky (1973) also suggests that women have a definite need for positive role models in order to feel validated. Although this was written over thirty years ago, Brodsky’s text still has relevance today, particularly in relation to the therapist’s role:

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\(^{17}\) Social activism is defined as “direct and meaningful activity related to improvement of the societal situations” (Brodsky, 1973, p. 27).
Perhaps the strongest message to be seen from the success of these C-R groups is that women are capable of using other women as models. Identification of women with role models of their own sex has been largely limited to the traditional homemaker roles or the feminine occupations such as teaching and nursing. The acceptance of more varied roles and personality traits in women will help to integrate a larger portion of women into the “mentally healthy” categories. (Brodsky, 1973, p. 28)

Orbach and Eichenbaum (1983), who have pioneered a combined feminist and object relations approach to psychotherapy, similarly cite the “major links” between the consciousness-raising process and feminist psychotherapy as follows:

- The personal is political – concern with the details of individual experience;
- Focus on the family – the family as our first social world;
- Importance of the emotional life of the individual;
- Focus on sexuality. (Eichenbaum et al., 1983, pp. 12-14)

Worel and Remer (1992), outlining their empowerment feminist therapy model, suggest that feminist therapy needs to include the following three principles:

- The personal is political;
- Egalitarian relationships; and
- Valuing the female perspective. (see Worel et al., 1992, p. 109)

Writing specifically about the influence of feminism on family therapy, Sandra Davidson (2001) argues that feminist therapy:

- Takes into account the cultural, environmental and historical context of both the counsellor and the client; and,
- Acknowledges the power dynamics of society as a whole as well as the power relationship within the therapeutic setting. (see Davidson, 2001, p. 6)

Common elements in these definitions are an analysis of power, and the inter-relationship between the micro and the macro systems of the individual and society.
Feminist therapy as a critique of the biomedical model

Historical analysis of the discourse of women’s mental illness suggests that the institution of psychiatry has been shaped as a tool to oppress women and lead them to social conformity under a patriarchal regime. (Joyce, 1997, p. 79)

Following Beasley’s definition of feminism as critiquing more traditional theoretical structures, we can also understand a feminist therapeutic framework as a reaction against the dominant biomedical model, for example, as well as being an approach in its own right. It can therefore be utilized to provide alternative approaches. Feminist art therapist Susan Joyce (1997), whilst highlighting the lack of a feminist perspective in art therapy publications, training and research, suggests that art therapists need to ask themselves the following questions:

Do feminist art therapists work with the mental health system, accepting the diagnoses and pharmaceutical treatments of their women clients, agreeing with the prognosis that they are clinically mentally ill? Or do we use our skills and knowledge to offer women an alternative form of treatment, by assisting them to become aware of the effects of social, political and economic oppression, the objectification and sexualisation of women’s bodies and the suspicion and low value associated with the female gender? (Joyce, 1997, p. 79)

The following chapter will revisit the question of how art therapy may be adapted by feminist therapy. What concerns me here is the use of feminist therapy as a critique of the biomedical approach to eating issues.

The biomedical approach views women’s problematic eating behaviour and consequent weight loss/gain as the core issue, and attempts to treat the symptom by physical means such as regular weight monitoring, bedrest, tube feeding and planned eating regimes, often reinforced by behavioural reward systems. It does not necessarily seek to address underlying causes, but, arguably, does perform a vital role in keeping dangerously underweight women alive.
The biomedical manner of treating women’s eating issues can miss the point of understanding them in context, i.e. as being expressions of social as well as individual dysfunction. Luepnitz (1988) demonstrates this in her analogy between anorexia and incest, and their symbolic function in our patriarchal culture:

Both anorexia and incest are supported by a social context that makes use of female fragmentation in many ways, with the result, as the Lacanian feminists might say, of reducing the “whole” to a “hole” – vagina or mouth. Both eating disorders and incest are expressions of female powerlessness, and their “cure” is female choice and authority. (Luepnitz, 1988, p. 225)

Feminist therapy as a critique of psychoanalysis

As mentioned briefly above, feminism has also impacted upon psychoanalysis, which is the theoretical basis of much of art therapy, especially as represented in the literature. As has already been discussed in earlier chapters, the psychodynamic approach, could be described as a “dominant” framework for art therapy. As we have seen psychoanalysis, and in particular object relations theory, focuses rather narrowly on the client’s inner world of objects and may not always make productive links with her external reality and social context. The addition of a feminist analysis, which widens this narrow focus, can perhaps only enhance our skill in treating and understanding our female clients. Luepnitz (1988) suggests for example that by combining feminist and psychoanalytic approaches, we can achieve a more comprehensive model for therapy which incorporates elements of both (pp. 168-195). Other psychotherapists who combine feminism and psychoanalytic approaches include: Susie Orbach and Louise Eichenbaum (1983; Orbach, 1982; 1986; 1994), Marilyn Lawrence (1979), and Ann Kearney-Cooke (1989; 1991).

Summarising the work of feminist object relations theorist Nancy Chodorow (1978), Luepnitz (1988, p. 181) argues that feminism and psychoanalysis can be mutually beneficial. By synthesising the two approaches, she argues, we end up with a richer and
fuller understanding of male and female psyche and behaviour by taking account of both social learning theories of feminism and psychoanalytic theories of gender.

The following section considers the work of psychotherapists Orbach and Kearney-Cooke, who have combined feminist and psychoanalytic concepts in their work with women with eating issues.

4.3 Feminist therapy with women with eating issues

“A body that feels wrong” (Eichenbaum et al., 1983, p. 169).

Sickness is not just an isolated event, nor an unfortunate brush with nature. It is a form of communication – the language of the organs – through which nature, society and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as the locus of personal and social resistance, creativity and struggle. (Lock & Scheper-Hughes, 1987, p. 31)

We shall now look at feminist perspectives on eating issues, in order to determine what art therapy may learn from this alternative approach. Much of the pioneering work in the application of feminist therapy to women with eating issues has been undertaken by feminist psychotherapist Susie Orbach. In her ground-breaking book on compulsive eating, *Fat is a feminist issue*, Orbach (1982, p. 16) suggests that we should understand compulsive eating behaviour as a symptom of a deeper problem. She describes her approach, using guided imagery to explore the function of the eating issue for the individual woman (Orbach, 1982). In other words, Orbach suggests (as do Crisp (1980) and Thompson (1992; 1994)) that the eating issue serves a positive purpose in the woman’s life at a particular time, in the sense of being an attempted solution to a deeper issue. Unless the underlying issue is addressed, it is her view that it is unlikely that the behaviour will change.
Orbach (1994) has also introduced the notion of the “false body”, in which she extends Winnicott’s (1965, p. 143) concepts of true and false self to explore women’s difficulties with distorted body image (including both anorexics and compulsive eaters). She describes the “false body” that the woman attempts to change in order to become more acceptable, or to “comply with what she imagines is acceptable” (Orbach, 1994, p. 169). As Fabre Lewin (1997) paraphrases, the false body involves:

…women having no sense of themselves inhabiting a stable, authentic and reliable physical basis of self. Instead we experience our bodies as a thing to be manipulated, done to, or displayed. (p. 120)

Eichenbaum and Orbach (1983) have suggested the underlying problem for women with eating issues is the emergence of the “true self”. This occurs through acceptance of the true body, which is usually hated and denied.

As previously mentioned, Catrina Brown (1993) has introduced the concept of a continuum of weight preoccupation in order to emphasise the similarities between various forms of eating distress and the general female population, stating for example that “today, women who are not concerned about their weight are the social anomaly” (p. 53).

Only a matter of degree separates those women who diet, work out, and obsess about their body shape and calorie intake from the more extreme behaviours of anorexia and bulimia...The tendency to separate the social obsession with thinness from anorexia and bulimia allows the latter to be treated as individual problems and isolated diseases, disconnected from popular culture and patriarchal society. (Brown, 1993, p. 54)

Brown (1993, p. 56) suggests that this “continuum framework” should form the basis of a feminist approach to eating issues, so that the “similarities between women” are emphasised, rather than the differences. The focus of therapy, Brown argues, should be on understanding what is behind the eating behaviour (p. 65). This is, importantly, often about being heard: “We need to hear the voices of individual women as they struggle
through their relationship with weight and eating” (Brown, 1993, p. 67). Brown’s solution is uncompromising 18, since she asserts that:

Overcoming weight preoccupation, giving up dieting, or accepting one’s body as it is, is by no means easy, but the only way off the treadmill is for women themselves to reject the value of thinness and rebel against its tyranny. We need to recognise the strength and courage it takes to rebel against predominant social values. Most importantly, we must recognise the necessity of our doing so. (p. 68)

Like Orbach (1982; 1986; 1994), Kearney-Cooke (1991) combines a feminist approach with object relations theory in her approach to women with eating issues. She focuses primarily on the role of the therapist in her elucidation of the “stage” model of treatment. As with other feminist therapists, she offers her definition of feminist therapy, and of the therapist’s role. She states at the outset that:

The important contribution of feminist theory is the recognition of gender as an organising principle of all behaviour, and of the way in which sexist social values and social structures become embedded in individual female psychology. (Kearney-Cooke, 1991, p. 295)

Kearney-Cooke (1991) outlines four specific ways in which this process occurs:

- **Woman as body** – in our culture, women are strongly identified with their bodies, as seen through male eyes, at the expense of their own identity;
- **Silencing of women** – in our society, women are encouraged to be submissive and to serve the needs of others before themselves. They fear that by voicing their needs, they will lose their supportive relationships with others;
- **Deprivation model** – women are encouraged to go without (food, equal pay, etc) and thereby self-control becomes more important than self-expression or self-determination;
- **Idealisation of the masculine** – women are seen as inferior as they lack a penis. Women’s capacity to form relationships is devalued and seen as indicative of weakness. (see Kearney-Cooke, 1991, pp. 298-300)

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18 Feminist academic Susan Bordo (2003), on the other hand, relates how when she lost twenty-five pounds in 1990, this was considered “inconsistent and even hypocritical” by some of her colleagues. She argues that feminism is not about telling women what to do, but about raising consciousness of “the power, complexity, and systemic nature of culture” (p. 30), thereby enabling individuals to make informed decisions in the context of their own lives.

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In any therapeutic relationship, the therapist needs to establish strong boundaries, to notice any patterns in how the client relates to others, and to avoid colluding with the client’s attempts to turn this relationship into “more of the same”. In working with women with eating issues, Kearney-Cooke argues, the therapist also needs to recognise the client’s strengths, and to assist women to “reclaim their bodies” (Kearney-Cooke, 1991, p. 298). For example, she suggests that the therapist give equal value to different female body shapes, and to “celebrate the seasons of the female body as expressed through menarche, pregnancy and menopause” (Ibid).

To address issues of deprivation, the role of therapy is to enable women to ask for (and to take) what they need. Feminist therapists, according to Kearney-Cooke, should attempt to:

…appreciate the complexity of women’s need to be both autonomous and connected, and…assist female patients to integrate both needs into a sense of self. (Kearney-Cooke, 1991, p. 300)

The feminist therapist also needs to encourage the client to reclaim her power and to understand how her eating is connected to her relationship issues. In summary, Kearney-Cooke (1991) argues that the feminist therapist has a more interactive and open relationship with her clients:

The approach described…challenges the therapist to step out of the role of a silent expert and to struggle actively with the patient…it challenges therapists to be clear about who they are and how they relate to others. It encourages therapists to be aware of their own struggles with shape and weight…It demands an understanding of the cultural context in which an eating disordered patient’s struggle takes place, as well as the provision of a relationship where the patient can clearly experience herself as having an impact on others. (p. 316)

This chapter has explored alternative, (non-art therapy) approaches to women with eating issues informed by feminist therapy. It has examined various definitions of feminism and of feminist therapy, including suggestions for practice. Three features which stand out are: first, that feminist therapists need to be aware of the social context of eating issues,
including both the continuum of weight preoccupation, and their own body image issues; second, that they may need to behave differently towards their clients, particularly in terms of role-modelling and providing support; and third, that both autonomy and relationships are significant treatment goals. An additional feature might be the adoption of a critical stance towards ‘traditional methods’, particularly the medical model. The following chapter builds an alternative art therapy approach on these foundations.
Chapter five: Foundations of a feminist-informed art therapy model for women with eating issues

Models of feminist therapy regard the impact of oppression on a woman’s life is a major cause of the ‘dis-ease’ which brings them into therapy. (Fabre Lewin, 1997, p. 116)

The previous chapter described some alternative approaches to women with eating issues informed by feminist therapy. This chapter uses the foundation of those approaches in building an alternative art therapy methodology. In recent years a feminist art therapy perspective has been developing, particularly through the publication of Susan Hogan’s edited book *Feminist approaches to art therapy* (Hogan, 1997a). There is still a relatively small number of publications which discuss feminist approaches to art therapy. The chapter examines these approaches. I shall consider feminist art therapy generally, and with specific reference to feminist art therapy groups, and then more specifically to feminist art therapy groups with women with eating issues, with a view to determining a framework for this alternative art therapy methodology. I shall also consider alternative therapeutic models such as solution focused and narrative therapy, which may have something new to inform art therapy approaches with this population.

5.1 Feminist art therapy

As previously discussed, there have only been a small number of feminist art therapy articles or publications to date, with few of them focusing on women with eating issues. Susan Joyce (1997, p. 79) has highlighted the scarcity of feminist art therapy publications and the lack of a feminist perspective in art therapy training. Indeed Helene Burt (1996) has suggested that art therapy may have the dubious distinction of being “the field that
has paid the least attention to feminism” (p. 12). This is in contrast to other modalities such as family therapy, which have been widely critiqued by feminist theory (Davidson, 2001; Luepnitz, 1988). Joyce (1997) argues that art therapy, in particular group art therapy, may offer women a more palatable alternative to traditional medical models of mental health care.

Art therapist and academic Susan Hogan (1997b) utilises feminist cultural theory to provide a theoretical framework for her approach. She identifies the potential of art therapy to be oppressive “if it relies on reductive theoretical formulations and focuses on the individual’s personality alone” (p. 20). Hogan argues that the way we look at images produced by women in our culture should be understood as existing within that culture, in the same way that we can view images of women in that context. For example, she suggests that “the analysis of images in art therapy should be seen in relation to other types of representation” (Hogan, 1997a, p. 21). This suggestion has important implications for the treatment of women with eating issues, since it directly relates to the way images of women’s bodies appear in the popular media, and provides a critical cultural lens through which to view art therapy images.

Feminist art therapy has similarly been defined by Judith Waldman (1999) as a movement outwards from the intrapsychic to the interplay between the individual and society:

In seeking a theoretical framework for the following case study...I found it essential to include an analysis of the sociocultural context within which the client developed her sense of self. It has become increasingly important to me in the past few years to move on from a purely reductive, intrapsychic view of emotional distress. (Waldman, 1999, p. 10)
Social art therapy: A new term

Waldman (1999) makes reference to Hogan’s (1997a) definition of “social art therapy” as recognising “the interconnections between (a range of) unequal power relationships…and how they are embedded in and sustained by practices of representation” (Hogan, 1997a, p. 28). Waldman (1999) describes how she used “a synthesis of ‘social art therapy’ and feminist theory to further develop (her)… own art therapy practice” (Waldman, 1999, p. 17).

Art therapist as role model

In the previous chapter, we saw how feminist therapy challenges the therapist to be seen as a positive role model for clients. Just as Waldman (1999) relies on other art therapists [Hogan (1997a), Wadeson (1997), Rust (1987) and Ellis (1989)] as “role models” in developing a feminist approach, she describes in her case study, how her client in turn saw her as a positive role model. This occurred through Waldman modelling assertiveness in defending the boundaries of the session, and in deviating from the psychodynamic norm of the “blank screen” (p. 14) approach, to enable the issue of the therapist’s Jewish identity to be discussed as it related to transference issues in her client’s dream.

Multiple perspectives

Nancy Viva Davis Halifax (1997) draws on feminist theory and feminist art practice to build her definition of feminist art therapy:
Feminist art therapy must be able to recognise itself as the daughter of feminist psychotherapy theory and feminist art practice, criticism and history. An understanding of feminist and contemporary art can support the development of a feminist and relational art therapy practice. (p. 51)

Davis Halifax argues that there is a parallel between the “modernist” approach to art history and practice, and the medical approach to mental health. Both approaches take a “single point perspective” (p. 50), and alternative approaches (such as women’s art practice in the case of art, and art therapy in the case of psychiatry) are frequently disregarded or marginalised. She argues for the consideration of gender and race, sexual orientation and ability in our therapeutic practice. Power issues (between client and therapist) need to be considered, as do the strengths and competencies of the client:

A feminist and relational model of therapy is able to value what each participant brings to the relationship. At its best, it is capable of containing and tolerating the confusion that may arise with the admission of difference, and multiple points of view. This kind of therapy suggests that people entering a supportive, collaborative, empowered, therapeutic relationship will carry that experience with them into their world…yet we must still acknowledge all that exists in our culture which will work against our newly acquired knowledge of self and of our capacity to do and act. (Davis Halifax, 1997, p. 51)

Summary of feminist art therapy

In considering how feminist art therapy may differ from a more ‘traditional’ psychoanalytic form of art therapy, we have firstly considered a range of issues that are adapted from feminist therapy, but are non-specific to art therapy. These include: increased awareness of socio-cultural issues, the art therapist as a positive role model; deviation from the “blank screen” approach; the importance of having a multiple perspective; a supportive, collaborative approach; adopting the goal of the empowerment of women; and so on. In a sense these are all attributes which relate to the underrated “non-specific factors’ in psychotherapy, identified by Asay and Lambert (2003), who suggested that “models and techniques…contribute 15 percent to change in therapy” (Duncan et al., 2004, p. 37). This issue will be further discussed later in this chapter.
The exception to these generic issues, however, is the consideration of representations of women, both within art history, and within popular culture. This consideration is specific to art therapy, since it uniquely locates art therapy within the dual spheres of aesthetics and cultural theory. The following points also explore what may be considered additional ‘unique qualities’ of art therapy from a feminist perspective.

5.2 Unique qualities of art therapy

In their description of an art therapy group for women in the community, Otway and Ellis (1987) claim that the use of art therapy offered the participants unique opportunities to meet their needs for support, space and the expression of feelings in a non-medical environment:

Since women are expected primarily to take care of others it is often extremely difficult for them to recognise or admit need for support. Afraid too of being unable to articulate feelings and of possible stigmatisation, women may be hesitant to approach somebody with whom they can talk over their fears…art therapy can offer a gradual way of exploring feelings, since its versatility can allow communication on many different levels. (Otway et al., 1987, p. 16)

Matra Robertson (1992) makes a link between feminist approaches to the treatment of eating disorders and the use of art in therapy, seeing art therapy as a break from more traditional treatment methods:

Feminist theory on anorexia nervosa and feminist psychoanalytic theory give rise to a greater sense of optimism about treatment for women who self-starve. Crisp (1980), Mitchell (1980), and Bruch (1973) have used art in their otherwise traditional treatment of women diagnosed as anorexic. Art can provide an avenue for expression of aspects of the self that are difficult to verbalise. Women can also use painting and artwork in a non-hierarchical, subversive manner to explore the diverse realities common to all women in a patriarchy. (Robertson, 1992, p. 71)

The use of art for encouraging non-verbal expression is familiar to art therapists. The use of art for “subversion” may be a less obvious and subtler “benefit” of art therapy. Sally
Skaife (1995) makes a similar point when she argues that “art therapy by its nature is radical. It is about empowering people…art therapy is nearly always a subversive activity” (Skaife, 1995, p. 2). The reasons given by Skaife include art therapy’s emphasis on imagination and play, its messiness, and its active involvement of the client. In addition, according to Skaife, its very antithesis to the medical approach emphasises the radical nature of art therapy (Skaife, 1995).

When compared to the biomedical approach to anorexia, for example, which is often forced to impose treatment regimes on unwilling patients, “for their own good”, art therapy may be seen as a much more palatable and less invasive form of treatment. The client may well perceive medical treatment as persecutory, abusive, invasive and judgmental, whereas art therapy (by comparison) is seen as empathic, empowering and fundamentally benign.

We have also seen however, that as Otway and Ellis (1987), Robertson (1992) and Skaife (1995) suggest, art therapy in and of itself may have unique qualities which make it particularly suitable for challenging the ‘dominant paradigm’, whether that be psychoanalysis or the medical model, and for working in a more empowering and sensitive way with female clients. This may paradoxically relate back to the consideration of non-specific factors mentioned in the previous paragraph.

The first part of this chapter explored some of the ways in which art therapists may need to modify their practice in order to incorporate a feminist approach. I have also explored some of the unique qualities of art therapy in meeting the needs of female clients. I shall now consider what has been documented on the specific topic of eating issues using a feminist art therapy approach.
5.3 Feminist art therapy groups

The following section looks at descriptions of feminist art therapy groups for women with eating issues. I have defined art therapy groups as “feminist” if, for example, the authors make specific reference to gender and socio-cultural issues, if they aim to empower women, if they are not aiming to “medicalise” women’s eating issues, and if they seem to be interested in exploring this alternative approach. In other words, they did not “accidentally” find themselves working in a particular way, or “happen to be working” with women clients, but made a conscious effort to do so, and in so doing, addressed their specific needs as women.

All these examples involve group work in a community setting, and often involve a non-art therapist as co-facilitator. This suggests that offering women alternatives to the medical model may require relocation away from the medical institutions; into group structures which enable their clients to benefit from mutual support and understanding, and which enable art therapists to work more collaboratively both with other practitioners, and with the clients themselves.

As mentioned above, Otway and Ellis (1987) describe a women’s art therapy group run by an art therapist and a social worker in the community. The authors identify one of the potential benefits of attending such a group for women with eating issues, namely increased awareness of the dynamic and conflictual relationship between the body and the self in the struggle for autonomy and self-realisation. The group was not specifically targeted at women with eating issues. According to the authors, however, at least two of the women attending used the group to work on their issues around eating and food:

An anorexic women in the group used the painting time to explore the unconscious meanings attached to her body image and eating patterns. Through her painted images she recognised the extent to which she used her body as a metaphor for her attempts to gain control over her life. (Otway et al., 1987, p. 17)

In another example from the group, a participant, the mother of a 14 month old child:
Used this time for herself to focus on her own feelings of anger and hidden longings for nurturing which she had tried to deal with through eating compulsively. (Otway et al., 1987, p. 17)

If we accept the hypothesis that eating issues exist on a continuum, it makes sense to address eating issues in generalist as well as in targeted groups. A possible benefit of the generalist group could be the exploration of this continuum, and how this affects all the participants. The group then can be a place where the eating issue can be seen as less stigmatised, and therefore less shameful. Groups can help to emphasise links between women participants, and not just highlight their differences.

The following case examples focus on groups that are specifically targeted at women with eating issues. Rust (1987), who has written extensively in this field, describes her format of group work with women with compulsive eating problems using art therapy and guided fantasy. This includes working on the connection between personal and political issues for these women. Rust is one of the first art therapy authors to attempt to introduce political and social factors as well as intrapsychic elements into the complex arena of art therapy practice with women with eating issues19.

Like Orbach (1982), Rust’s (1987) work also breaks new ground in considering compulsive eating as a separate category, as distinct from the more familiar anorexia or bulimia, which feature in most clinical case studies. The significance of this is that compulsive eating is not defined as a psychiatric diagnosis, so represents a “less clinical” group, which can be treated in the community.

The first few weeks of Rust’s (1987) groups concentrate on “the immediate problem of panic around food” (p. 145), and subsequent weeks focus on body image (Ibid). There is

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19 This is reflected in her chapter’s publication in a feminist compilation of articles about women and eating issues, Fed up and hungry, edited by Marilyn Lawrence (1987) from the Women’s Therapy Centre in London.
a deliberate search for the meaning behind compulsive eating behaviour, using guided imagery and magazine photo collage.

In Rust’s (1987) groups, the participants use visualization and collage, as an extension of the guided fantasy exercised described by Orbach in *Fat is a feminist issue*. The “Fat/thin fantasy” (Orbach, 1982) involves the client imagining she is at a party as a thin version of herself, as a fat version of herself, and finally as an idealised version of herself. She then examines her emotional reactions to her different imagined body sizes. The aim of the guided fantasy is to discover the associations each individual woman has with being thin, fat and her ideal size (pp. 276-278). Rust (1987, pp. 145-155) has extended this guided fantasy into a collage activity which explores the plethora of visual images and stereotypes of women from which participants may be struggling to find their own identity.

“The main task”, according to Rust (1987), “is the separation of the fat and thin” (p. 147). Rust found that women had varied associations with being fat and thin, for example:

Some women feel more powerful, independent and adult when fat and powerless, dependent and childlike when thin, while for others the reverse is true. (p. 148)

This suggests that there are no universal ‘values’ attached to being fat or thin, but that they are indeed a product of one’s immediate environment and wider culture. It also suggests the need for therapists to be aware of these individual differences, and to avoid making assumptions about meaning and symbols. Rust’s reference to the terms “powerless” and “powerful” led me to one of the activities I used in the project in which women were asked to choose images that depicted these two opposing but related concepts (see chapter seven).

Rust (1987) describes the conflict many women with eating issues feel in terms of expressing their needs and desires. This can centre on ideological conflict, with for example “unacceptable” female images, or archetypes, in the Jungian sense, being
repressed. Rust (1987) argues that the use of guided fantasy and collage can free the compulsive eater “to experiment and explore in her fantasy the different images which both attract and repel her” (p. 153). These female images, Rust suggests, are “almost mythological in nature” (p. 154), for example “the helpless woman saved by the knight in shining armour, the seductive woman in lace underwear, the glamorous lady in high heels, make-up and slim-line clothes, the cool, sharp, intelligent business-woman, the all providing earth-mother” (Ibid). If the woman is able to integrate these needs and desires within herself, rather than by association with these “unacceptable” archetypes, Rust argues, change may be able to occur.

Rust (1987) describes the depth of meaning within these women’s collages, which gives further opportunities for exploration. She suggests that the participant “can begin to see what belongs to her (i.e. personal) and what is of society (i.e. political), thus tracing back the conflict to its roots and hopefully freeing it” (Rust, 1987, p. 154). Rust also suggests that group work enables women to understand both the differences and the similarities between themselves and other women. The groups she describes are highly structured and involve directed activities, which are chosen for their pertinence to the themes the women are struggling with. She suggests these exercises would be suitable for bulimic and anorexic women as well as compulsive eaters.

In a later work Rust (1992) includes all three categories of “eating disorders” she is concerned with (anorexia, bulimia and compulsive eating). Rust (1992), who describes her work as being based on “a model derived from object-relations and feminist psychotherapy” (p. 155), briefly touches on contextual issues such as patriarchal society and the images women are surrounded by in our culture. She identifies the “madonna/whore split” in terms of opposing images of women, and quotes feminist writer Kim Chernin’s (1981) analysis of bodily meaning through which emotions are expressed.
Rust (1992, p. 160) outlines in some detail the psychodynamic model of art therapy, which she describes as the model most favoured by art therapists working within the field of eating disorders, a bias which is certainly supported by the literature. Rust, like other psychodynamically oriented art therapists, focuses mainly on the therapeutic relationship between the client and the therapist, which she describes as being a re-experiencing of the early relationship the client had with her mother.

Rust (1992) describes the work of Susie Orbach and Luise Eichenbaum (1983) in their merging of psychoanalytic theory derived from object relations with a gender analysis, which considers cultural pressures and expectations as they impact on women. The focus however is still on the mother daughter relationship rather than on other events and relationships in women’s lives. Neither the role of fathers, brothers and boyfriends, nor the clients’ experiences of rape or sexual assault, is explored.

The body is seen by Rust (1992) primarily as the carrier of unconscious messages from the woman to the outside world. As with Levens (1987; 1990), Rust (1992) suggests that the process of art therapy can “enable the client to bridge the gap between inner feelings and words” (p. 162). She describes the various ways in which this can occur as follows:

The art object as intermediary preconscious messenger…the art object as a means of reaching the gut…the art process as an arena for making a transitional space…the art object as a tool for enactment…the art object as a mirror…the art process as a contained out-of-control space… (and) the art process as a means of reaching a metaphorical way of perceiving. (see Rust, 1992, p. 162-166)

In considering, for example, the art object as a mirror, Rust (1992, p. 165) describes how, in her view, the client looks to the therapist and the group for a “reflection of herself…how she looks and who she is” which points both to the importance of the therapist as a role model, and to the value of the group in providing additional role models.
In a later work Rust (1994) describes her facilitation of three art therapy groups for women with compulsive eating problems at the Women’s Therapy Centre in London. The groups were time limited (one year) and were described by Rust as “analytic art therapy groups” (p. 48). In contrast to Rust’s earlier work, the groups were basically unstructured and non-directive. She writes about the composition of these groups, in particular noting that it is more useful to have “two of a kind” (p. 52) in the group (i.e. two women who are larger than the rest) so that an individual is not singled out as being different in a detrimental way.

Rust (1994) acknowledges her initial fear of being too “controlling” in differentiating between painting time and discussion time within the group, although when the degree of structure was adjusted between the first and second groups this enabled the participants to make better use of the group. Rust seems torn between her belief about what the “proper” way to facilitate such a group might be, and what actually seems to work for these women. She has a heightened awareness of issues of control which exist for this client group, but at the same way has a cool observer’s interest in comparing the women’s fears and their eating behaviours:

For them to be plunged into something so unboundaried seemed too paralysing, despite the useful parallels with their eating problems. (Rust, 1994, p. 53)

Later she writes that:

…at this stage (early in the group) there is often mention of bingeing before or after the group, indicating the lack of a good feed during the session. (Rust, 1994, p. 54)

Rust makes the connection between eating issues and sexual abuse in terms of lack of boundaries and (paradoxically) a strong need to be in control. In one particular group, where seven out of eight participants had been abused as children, men were identified as the abusers and the Women’s Therapy Centre was seen as a safe haven. Rust describes how one woman’s clay sculpture of a large cobra became, using Shavarein’s (1987; 1992) term, an “embodied image” for the group:
It (the cobra) was placed in the middle of the group, squarely facing me. When we sat down together I waited with baited breath, sensing the volcano about to erupt. The woman (who made it) described the snake as a “dick”...the group seemed to be enthralled, frightened and outraged; the “man” had come into the room without a doubt. They spent a good deal of time looking at this object and talking about it. So much was contained in this image. They felt as though things were being dredged up from the bottom of a pond like monsters from the deep. (p. 55-6)

Rust describes how she experienced strong counter-transference feelings of being unable to protect these women due to the number of “intruders” who came into the room in the course of this group. This experience had a parallel for Rust (1994, p. 57) with the experience of their mothers who had been unable to protect them from sexual abuse as children.

In Rust’s (1987; 1992; 1994) extensive writing on the topic of art therapy with women with eating issues, she indicates her choice of a feminist-informed framework for practice, although this is not always extensively documented. Rust’s (2000; 2004a; 2004b) more recent work, since she underwent a Jungian analytic training, does not mention art therapy so often, although she still writes about her clinical work (now in private practice) with women with eating issues. She is clearly still interested in cultural issues, with her focus widening to incorporate environmental issues as well. I shall now consider some of the other examples of art therapy group work with this population.

Ball and Norman (1996) describe a 14-week art therapy group with women with eating issues in the community. The authors discuss the benefits of group work, such as mutual support, understanding and development of self. In addition, according to Ball and Norman, the participants are able to re-experience historical traumas, take risks, and explore new ways of relating. Ball and Norman describe common features in their work with women who use food, such as the mother-daughter relationship, and food as a method of control.
Art therapy was used in the group the authors describe, as one of the co-facilitators was an art therapist, and they state that this provided the women with a means of non-verbal expression (see Ball et al., 1996, p. 55). This was displayed through the use of art materials in relation to some of the themes expressed in the group, which included:

The inability to take in and retain anything good; the potential for the “good” to become damaging or to be destroyed by the bad; a fear of endless and overwhelming need within the group; the desperate desire to eat which may then be replaced by guilt and self-reproach; and the need to get rid of food. (Ball et al., 1996, p. 56)

Ball and Norman (1996, p. 54) employed a non-directive, psychodynamic approach, in conjunction with a feminist framework, in which themes were not set, except in the early sessions of the group, and the content of the group was determined by the participants. Safety was established through the negotiation of ground rules in the first session (Ball et al., 1996, p. 55).

Ball and Norman (1996) describe the balancing act they performed in meeting individual needs as well as addressing group dynamics. In much of the other art therapy group work mentioned in the literature, the focus is on individual pathology and progress, rather than on group themes, with the exception of Rust (1994), Waller (1993) and Johnson and Parkinson (1999).

Ball and Norman (1996) finish their article with a list of recommendations for workers with women with eating issues, which supports their values and basic approach. These can be found in the Appendix G of this thesis, with those of other therapists.

Their article is unusual in the art therapy literature; in that it gives a thorough explanation of the context of the group work undertaken at the agency, Northern Initiative on Women and Eating (NIWE). There is a sense of the bigger picture, and also that principles of feminist therapy are being put into practice, in quite concrete terms. For example, the women had a choice about which group they participated in, and they were provided with
information about art therapy prior to the group. Other factors adopted by the agency as a whole, and listed in their recommendations (Ball et al., 1996, pp. 58-60), included its policy of non-labelling, its non-medical, non-behavioural approach, a “non-expert” role adopted by workers, the range of services offered, and the potential for women to self-refer.

Echoing Kearney Cooke (1991), Ball and Norman (1996) recommend that therapists reflect on these issues themselves:

It is very important for workers working with women with eating problems to examine their own feelings about food, eating and body image. How a worker feels about fatness, thinness, diets, comfort-eating, fashion, mealtimes etc. may influence how she feels about the work with women. It will be important to know why issues arising from the work arouse feelings in the worker. These issues can be explored in a confidential worker group or through supervision. (Ball et al., 1996, p. 59)

This chapter has so far reviewed feminist therapy and in particular feminist art therapy groups, exploring alternative treatments for women with eating issues. What follows examines other models (i.e. non-art therapy, non-feminist therapy) for a range of alternative approaches to working with this population. The models explored include: solution focused therapy; narrative therapy; and cognitive behavioural therapy; which has been described as one of the “therapies of choice” for eating disorders (Bryant-Waugh & Lask, 1995; Howell, 1994; Matto, 1997). My purpose is to discover if these models can enhance or inform art therapy methods for a better, more client-friendly approach with women with eating issues.

I also consider so-called “common factors” in therapy, as identified by Duncan et al (2004, p. 37), who suggest that specific therapeutic techniques are less important than most practitioners may imagine. Their view challenges us to see art therapy as one of many useful therapeutic approaches, which is not necessarily “better or worse” than any other technique.
Even more challenging, perhaps, is Catherine Garrett’s (1998) assertion that psychotherapy is not necessary in the process of recovery from eating issues. I briefly look at her research which investigated methods of healing used by individuals already recovered from eating disorders, towards the end of this chapter.

5.4 Alternative therapeutic approaches

In what follows, I seek to explore the contributions from other modalities (non-art therapy) as they have been used in treating women with eating issues. Several of these approaches (solution focused and narrative therapy) are derived from family therapy.

Solution focused therapy

A solution focused approach to treatment for eating issues has been outlined by Frederike Jacob (2001). Jacob describes the development of solution focused approach by Insoo Kim Berg and Steve de Shazer in the 1980’s in the USA. Some of the features of this approach include: “looking for exceptions… being future oriented, and collaboratively devising small, achievable goals” (Jacob, 2001, p. 9). It may also involve amplifying clients strengths and abilities and empowering them by “constructing and developing solutions” (p. 14). One strategy for achieving this is the ‘miracle question’ (Jacob, 2001, pp. 21-25), which enables the client to start considering the possibility that their problem will be solved. Another is the use of scaling questions, in which the client rates an aspect of their problem on a scale of 1-10. (Ibid, pp. 25-27).

Jacob (2001) argues that the solution focused approach treats the client as being an “expert in their life” (p. 17) so that the therapeutic relationship is “based on equality and mutual respect” (p. 17). As Jacob states, “this is in contrast to the hierarchical approach of psychodynamics (in which)…the therapist is superior, the client inferior” (p. 17). In
addition, therapists “demystify the therapeutic process by explaining to clients exactly what counseling entails, so that they can give their informed consent” (p. 17), and they avoid the use of jargon.

Many of these factors, based on solution focused therapy, have points of similarity with a feminist approach, which we have explored previously. (An example of this would be the demystification of therapy through transparency.) This is perhaps not surprising since the solution focused approach is a “new order” form of family therapy, after family therapy was reformulated by social constructionists, through the impact of post modernism (Jacob, 2001, p. 9). This deconstruction of family therapy clearly involved a consideration of multiple perspectives, including gender, and their significance in therapeutic practice, which also has resulted in a feminist critique of, approach to, family therapy (Luepnitz, 1988).

Narrative therapy

Narrative therapy, like solution focused therapy, derives from family therapy and belongs to the post-modern “constructionist” school in which:

Meaning is known only through social interaction and negotiation. We have no direct access to objective truth, independent of our linguistically constructed versions of reality. (Jacob, 2001, p. 9)

As with feminist therapy, one of the features these “new order” therapies share is that of challenging the existing methodology, and thereby providing a critique of pre-existing treatment methods, as well as offering alternative, “new improved” strategies and techniques. This is demonstrated in the following example.

David Epston, Morris and Maisel (1995) developed a narrative therapy approach to anorexia/bulimia as a reaction against the medical approach to women with eating disorders. The authors became concerned that:
…the objectifying practices of weighing, assessing, and measuring of women associated with the discourses of psychology and psychiatry could very well co-produce what is referred to as anorexia/bulimia in those very persons oppressed by anorexia/bulimia. (Epston et al., 1995, p. 70)

In narrative therapy, letters and other narrative forms are used to encourage clients to understand their condition as a construct rather than a reality. A narrative that has been constructed, clearly, can also be deconstructed.

In her autobiographical account of her recovery from anorexia, De Pree (2004) uses the same metaphor as narrative therapy. She writes that for women with anorexia:

> Starvation is a form of communication that offers the body as a text to be read. Its message articulates a subtle cultural protest. The protest concerns the societal ideal...her emaciated form reveals the oppression of thinness by manifesting a dangerous exaggeration of this ideal. (p. 55)

On the process of recovery, she writes:

> The compulsion to restrict my food intake still catches me unaware. Writing this story is allowing me to get past it (p. 53)

Epston et al’s approach is to encourage persons with anorexia/bulimia to see the condition as a colonising force\(^{20}\), which is taking over their life and mind, rather than a definition of their “illness” and ultimately of themselves. This approach has been coined “externalising the problem”, and is a technique frequently used in both narrative and solution focused therapy. The concept of externalisation is based upon the idea that seeing a problem as external to the self may make it much easier to deal with, both emotionally and cognitively. This is a concept which will not be unfamiliar to art therapists, who would perhaps argue, that a visual representation of the problem, rather than a verbal construct, is an even more potent agent of change.

There is also an oblique parallel here with the feminist approach, since the feminist consideration of the client’s cultural milieu in effect suggests, that part of the problem is

\(^{20}\) This is similar to Claude–Pierre’s (1997, p. 37) assertion that there is “a civil war in the mind” between, in her terminology, negative mind and actual mind.
external to the individual client. The concern with avoiding diagnostic labels, and with empowering clients, is also congruent with feminist therapy.

_Cognitive behavioural therapy (CBT)_

I shall now consider Cognitive Behavioural Therapy or CBT, which has traditionally been seen as somehow “incompatible with”, or “antagonistic to”, a psychodynamic approach, an idea which I was inculcated with in my art therapy training, and which I had to challenge when I first worked in an agency which mainly utilised a CBT approach.

CBT is often cited as the treatment of choice for adults with eating disorders (APA, 1993; Bryant-Waugh et al., 1995, p. 25). However CBT approaches are not frequently cited by art therapists (Rosal, 2001), although Rosal did find a small number of articles which combined these approaches. Art therapists may see CBT as theoretically incompatible with psychodynamically oriented art therapy. This may be due to a variety of reasons, which I will briefly outline.

One possible explanation of art therapists’ avoidance of CBT is the history behind its development. The first strand of CBT, called Rational Emotive Therapy (RET), which is essentially concerned with cognitive restructuring, was developed by psychologist Albert Ellis in 1962 (Rosal, 2001). Ellis conceived of his approach as being a reaction against psychoanalysis, of which he was very critical (A. Ellis, 1968).

From a psychodynamic perspective, an aspect of CBT art therapists may find challenging is the fact it denies the existence of the unconscious, and focuses only on conscious thoughts, and their effect on feelings and behaviour. CBT is based on social learning theory rather than psychoanalysis (Rosal, 2001, p. 211). Indeed CBT encourages us to
see feelings as being entirely derived from irrational thoughts, which can be disputed and corrected, rather than from the unconscious conflicts upon which psychotherapy is based.

Two further aspects of CBT are noteworthy: first, it has been presented as a scientific approach which can be scripted, manualised and delivered by any practitioner; and second, it has a strong research focus. Duncan, Miller et al (2004, p. 41) argue that these two factors have resulted in CBT being studied and researched more than other methods, which has created the impression that it is therefore more effective, a claim denied by Duncan et al. (2004, p. 41). CBT is also an approach most suited to higher functioning individuals, who may in themselves have a better prognosis. It is often presented as a short term package, which may also make it more appealing in the current economic climate, and the manualisation gives the impression that it can easily be delivered without the need for expensive and lengthy training. It is also a technique most utilised by psychologists, who may be seen as being more allied with the medical model, and therefore having a higher status than art therapists, for example (Joyce, 1997).

Rosal (2001) argues that CBT can be usefully combined with art therapy for a number of reasons. She sees art as “an inherently cognitive process” (p. 217) which involves “uncovering mental images and messages, recalling memories, making decisions, and generating solutions” (Ibid). Rosal suggests that the main purpose of a CBT approach is “helping a client...to develop an internal sense (locus) of control” (p. 223). Since control is an issue frequently identified in relation to eating issues, and given CBT’s suitability with this client group, it would seem a useful area for art therapists to explore further.

One art therapist who does write about utilising a CBT model with women with eating issues is Holly Matto (1997). Matto sees art therapy and CBT as being complementary approaches, and suggests that art therapy may help overcome some of the disadvantages of a purely CBT approach, for example by allowing the emotional expression derived from art therapy to balance out the more cognitive bias of CBT, thereby avoiding
“perpetuating the intellectualisation of the disorder” (p. 348). One method Matto describes, is the use of art therapy as a starting point in the session, which is then followed by an exploration of the thoughts and feelings which emerge from both the art-making process and the artwork itself. She suggests this may help with reducing anxiety in relation to difficult emotions, for example (p. 349). Matto describes working both directly and non-directively, and utilises body contour drawing as one of the methods for working with body image disturbance, seeing this as an example of cognitive restructuring. Matto argues that the complexity of eating issues demands an integrated approach which combines art therapy and CBT, and which incorporates hospital based and community treatment.

I have briefly described how CBT, solution focused and narrative therapy approaches may be incorporated into an art therapy framework when working with eating issues. The following section takes this integrative approach further in exploring the concept of “common factors” in psychotherapy.

5.5 Non-specific factors in psychotherapy

I have already briefly considered the solution focused approach and suggested it may have something to offer art therapy with women with eating issues. I have also made occasional mention of recent research into the “common factors” in therapy. Both of these disciplines, or lines of enquiry, have aimed to deconstruct previously held notions of psychotherapy and turn them on their heads. Perhaps then it is not surprising that before they became more interested in researching the effectiveness of therapy, Scott Miller et al were practicing, and writing publications on solution focused therapy (Duncan, Hubble, & Miller, 1996). The client focus and seeing the client as “expert”, seems to have led them to their passion for investigating and honouring the client’s perception of therapy.
Research into common factors, as identified by Asay and Lambert (2003) will firstly be considered. This research, which I have briefly mentioned earlier in this chapter, has important implications for all forms of psychotherapy. Asay et al (2003) present their analysis of research and meta-analysis of psychotherapy studies, which shows that psychotherapy is generally effective, and that its therapeutic effects are generally sustained over time, regardless of the specific factors used in the approach adopted by the clinician\textsuperscript{21}.

The authors argue that, on the basis of their analysis, the common factors in psychotherapy (for example, empathy, warmth, acceptance, encouragement of risk-taking, and other elements of the therapeutic alliance) account for 30\% of improvement; external factors (for example, client strengths, social support) account for 40\%; 15\% of improvement is caused by placebo effects; and only 15\% is caused by therapeutic techniques or specific factors (Asay et al., 2003, p. 30-31).

Beresin, Gordon and Herzog (1989) make the same point in their phenomenological study of 13 women who have recovered from anorexia. The authors found, paradoxically, that:

\begin{quote}
About 90\% of the group rated some professional help as among the five most helpful and five most harmful experiences related to recovery. (Beresin et al., 1989, p. 114)
\end{quote}

And that:

\begin{quote}
Ideal qualities of the therapist include honesty, consistency, reliability, and flexibility...according to the subjects, it is important to depart from the technically neutral position and provide explanations about the eating disorder, coaching, and encouragement. The patients uniformly reacted negatively to inexplicit goals, inactivity, silences, and formality. (Beresin et al., 1989, p. 114)
\end{quote}

This research challenges therapists of all hues to reconsider their allegiance to particular models or methods of working and to reassess their approach, since it strongly suggests

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\textsuperscript{21} A specific factor in the case of art therapy would be the availability and use of art materials in the session.
that what therapists think is most effective, is often less so according to their clients.

Duncan et al (2004) make a similar point when they give the following caveat:

When anyone claims differential efficacy for an approach, be suspicious. Recall that the number of studies finding differences are no more than one would expect from chance. Further, close inspection of studies that claim superiority reveals two major issues that must be considered: allegiance effects and indirect comparisons. (Duncan et al., 2004, p. 42)

Allegiance effects are defined as “the therapist or researcher’s affinity toward the treatment at hand” (Duncan et al., 2004, p. 42). Indirect comparisons are defined as “experimenters pitting their pet approach against a treatment as usual or a less than ideal opponent” (Ibid).

This latter factor, allegiance effects, would of course refer to art therapists as much as any other psychotherapists. This research challenges art therapists to revisit the common factors of psychotherapy, and to have a more flexible approach in their utilisation of art activities in order to better meet their client’s needs.

It is however important to state that art therapy, and the expressive therapies generally, have not been included in these meta-analyses of psychotherapy. In his review of Roth and Fonagy’s (1996) publication on psychotherapy research, Jones (1998) notes how “art therapy …is not included or referred to in the book” (p. 76), which in this case is due to the authors’ insistence on using randomised control trials as their evidence base. Roth and Fonaghy make a case similar to Asay and Lambert (2003), and Duncan et al (2004) for the importance of common factors in psychotherapy as agencies of change. Jones however is concerned that “the specific factor of the image in art therapy” would be seen as the precursor to “a ’common curative factor’ that allows healing to begin, rather than the adoption of a particular theoretical orientation” (p. 76). Jones seems to be alarmed by the potential for the ‘dumbing down’ of art therapy in this environment.

However, in an important aside to this debate, Orlinksky, Grawe and Parks (1994), in their meta-analysis of therapeutic factors, found that “the quality of the patient’s
participation in therapy stands out as the most important determinant of outcome” (Duncan et al., 2004, p. 36). Duncan et al continue with the assertion that “the research indicates that therapy works if clients experience the relationship positively and are active participants” (Ibid, p. 36).

Since active participation has already been identified as one of the key features of art therapy (Robertson, 1992; Skaife, 1995), when compared to say verbal psychotherapy, or, particularly, the biomedical approach, this may indeed suggest valid grounds for art therapy’s claim to be particularly beneficial for women, since they are no longer the passive recipients of treatment.

Active participation does not just refer to the use of art. It can also refer to ‘opening out’ the therapy to involve the client in a consultative process, in which they provide feedback on their experience of therapy to the therapist. By addressing the power dynamic in the therapeutic alliance, and inviting the client to have a greater role in their own treatment, (whether by use of art or by discussing the progress of therapy with the client) it seems art therapists may be able to capitalise on some of art therapy’s unique qualities which are already working in their favour, in further meeting the needs of their clients.

5.6 Is therapy necessary?

Sociologist Catherine Garrett’s (1998, p. 65) approach to researching eating issues is to question the need for therapy at all. Her research method involved interviews with thirty four Australian individuals “who would once have qualified for a psychiatric diagnosis of ‘anorexia nervosa’, and believed they had now recovered” (p. 19). Garrett’s research was qualitative and encouraged those who participated to “tell their story” (p. 23). Her research focused on recovery rather than illness, which she argues, is not the usual kind
of eating issues narrative, because “suffering and disruption can be displayed more concretely than their opposites” (p. 42).

Garrett (1998), who strongly rejects the medical approach to eating disorders, outlines the following elements of recovery from ‘anorexia’:

- Abandoning obsession with food and weight;
- Strongly believing that they would never go back to starving, bingeing and purging;
- Developing a critique of social pressures to be thin;
- Having a sense that their lives were meaningful – existentiality or spirituality;
- Believing they were worthwhile people and that the different aspects of themselves were part of a whole person;
- No longer feeling cut off from social interaction. (see Garrett, 1998, p. 67)

Unlike the medical model approach, Garrett (1998)’s focus is entirely on thoughts and beliefs rather than behaviours or weight/physiological factors. This might suggest that a psychodynamic approach would be more acceptable than a medical or behavioural approach, but at times (unhelpfully) she does not differentiate between psychiatry and psychotherapy when critiquing her participants’ stories:

   Psychotherapy and psychiatric treatment…have now received considerable criticism and during the course of my conversations I heard horrific accounts of force-feeding, of inappropriate gynaecological treatments, of behaviour therapy and of hospital psychiatrists who were more interested in the ‘case’ than in the person. (Garrett, 1998, 75)

Garrett (1998) takes a sceptical view of the efficacy of psychotherapy, as evidenced by the citation above, although she is clearly interested in the value of “telling a story”, or the significance of narrative, and the related art of narrative therapy, to which she briefly makes reference (Garrett, 1998, 41-42). In citing the small scale phenomenological study by Becky Thompson (1994) *A hunger so wide and so deep*, for example, which takes a multi-racial sample of American women with eating problems, Garrett highlights the fact that “only a few women in (Thompson's) …study sought therapeutic help” (Garrett, 1998, p. 66). Garrett appears to cite this statement, which is quoted out of context, in
order to underline her point that “to be free of an eating disorder it is not mandatory to articulate its origins” (Ibid, p. 66).

However, on referring to Thompson’s (1994) original material, we discover that Thompson actually stated that although most of the women did not seek therapy, the majority of them (10 out of 18) did receive therapy or counselling, and stated that it had helped (Thompson, 1994, p. 115). In fact therapy, followed closely by attending 12-step programs, were the most frequently cited events which were deemed helpful. Thompson’s point is that psychotherapy alone was not effective in their recovery, but that other events such as ‘coming out’ (as a lesbian), moving away from family/or husband, going to a 12-step program, or going to college, were also cited by a number of participants as significant events in their recovery (Ibid, p. 118).

Garrett (1998) acknowledges that some of the participants in her own study did benefit from therapy, although many of them (nine out of fifteen of her ‘recovered’ participants) stated they had received “none”. The majority of treatment cited was psychiatric, and it is possible that other forms of psychotherapy may not have been available, given the dearth of psychotherapy options in Australia compared to the United States (Gilroy & Hanna, 1998).

Garrett (1998) anticipates Asay et al (2003) when she states that for her own research participants who did find therapy helpful: “it was the person and the relationship which they remembered as having been important, rather than any particular therapeutic technique” (p. 75). In other words, it was the non-specific therapeutic factors that her participants identified as being helpful. Interestingly however, Garrett also cites various creative activities as being beneficial to her participants, such as “story telling and writing” (p. 78), “quiltmaking and elaborate knitting” (p. 78), enrolling in art school (p. 78), having children (p. 76), and “the creative endeavour of self-transformation” (p. 77). An example of this final activity follows:
Jacqueline’s artistic project; to paint 200 shades of grey, was the beginning of her exploration beyond the black and white world of her anorexic existence. (Garrett, 1998, p. 78)

Garrett (1998) also offers the following personal example from her own journey of recovery:

On my fortieth birthday I cleared my desk of its computer and books and spent the weekend painting a large portrait of my house. (Garrett, 1998, p. 15)

Garrett (1998, p. 79) concludes that “creativity plays a vital role in recovery”, citing the “non-linear, non-evolutionary nature of both creativity and recovery” as a means of understanding these related processes more clearly.

This chapter has examined a variety of different approaches, all of them deviations from the usual art therapy approach, and some of them not involving art therapy at all, in order to discover methods which may be more useful and more empowering for women with eating issues. I have firstly described feminist approaches to art therapy in general, and to art therapy groups for women with eating issues. I have also looked at therapeutic methods from other disciplines; most notably those derived from family therapy, such as solution-focused and narrative therapy, as well as cognitive behavioural therapy, in order to determine what approaches may be beneficial for these clients. I have aimed to show how art therapy may be able to incorporate concepts or approaches from these disciplines to become more responsive to clients’ needs.

I have also considered Duncan et al’s hypothesis that specific therapeutic methods are less significant to clients than the “non-specific factors”, which centre on the quality of the therapeutic relationship, since this has profound implications for all psychotherapeutic practice. In addition, I have looked at Garrett’s suggestion that therapy may not be necessary in recovering from eating issues.
In considering these alternative approaches, we have, paradoxically, also discovered some good arguments for the benefits of art therapy, in particular: the importance of visual images in art and popular culture; the benefits of active participation; combining emotional and cognitive processes; externalisation of ‘the problem’; and the value of creativity in recovery. Thus I hope to have shown how art therapy may both adapt and grow, and how it may already be demonstrably beneficial. The following chapter will describe the feminist informed therapeutic methodology, which incorporates many of these approaches, that was developed for this case study.
Chapter six: Design and methodology
for exploring feminist-informed art therapy practice

6.1 Introduction

The previous chapter explored some critical strategies with regard to building an alternative, feminist informed art therapy model. This chapter will begin to describe the project I developed, which consisted of a short term art therapy intervention for women with eating issues in a community setting, which attempted to incorporate some of those strategies. First, I will outline the research methodology that was developed for this project, based on the art therapy and feminist therapy literature. The methodology that was selected was chosen with a view to addressing the issues outlined in previous chapters, such as the inclusion of clients’ voices and images, a feminist focus, and a community based approach. Second, I shall describe the socio-cultural climate surrounding the research project, some of the issues which I encountered whilst setting up the project, and the development of the research instruments. The project itself is described in detail in form of a dual case study in chapter seven.

6.2 Research methodology: Overview

The first part of this chapter describes the methodology utilised in this research project. The methodology I used was derived from a number of sources, starting with art therapy research, both in general, and with particular reference to case study methodology, research into therapy groups, feminist therapy research, and various combinations of the above, as they relate to women with eating issues. I have also included a section on visual research, in order to consider approaches for incorporating images in research. I will now discuss these sources in turn.
A general observation made quite frequently in the literature is that there is not enough research being conducted on art therapy and its effectiveness with various clinical groups (Edwards, 1996; 1999; Gilroy, 1995, 1996; M. Wood, 1996). Suggestions have been made about how more art therapy research may be carried out (McNiff, 1987; 1998) using alternative, qualitative methodologies (Burt, 1996; Wadeson, 1989) or more traditional, quantitative measures (Burleigh & Beutler, 1997; Jones, 2002; Males, 1980), or indeed a combination of the two (Dudley, Gilroy, & Skaife, 2000; Gilroy, 1996).

Kevin Jones (1998), in his review of Roth and Fonagy’s (1996) overview of psychotherapy research entitled *What works for whom?*, commissioned by the British Department of Health, notes that art therapy was not mentioned in their report. However, Jones picks up on the authors’ point, that the common factors in therapy are most important:

> They consider that the difference in effectiveness of therapies may lie in the differential way they allow common curative factors to come into operation rather than the extent to which specific factors are brought to bear. (Jones, 1998, p. 76)

Jones (1998) states that Roth and Fonagy’s (1996) argument:

> …suggests that perhaps the specific factor of the image in art therapy facilitates a ‘common curative factor’ that allows healing to begin, rather than the adoption of a particular theoretical orientation. (Jones, 1998, p. 76)

Jones does not appear to find this a useful concept and neither does Chris Wood (1999) who, referring to Roth and Fonagy’s (1996) argument, writes that “it could undermine a good deal of the therapeutic clarity which has been developing in the profession” (C. Wood, 1999, p. 55). She continues:

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22 These methodologies have been more successfully utilised by psychologists than art therapists (Edwards, 1996; Hagood, 1990).
It seems politically and professionally wise to develop methods over time that enable us to gather our own constellation of evidence, which is, art therapy specific. (Ibid, p. 55)

This last statement reminds us that the debate about evidence and research is taking place within a specific political climate and context, and can therefore have huge implications for future employment and for the development of the profession of art therapy.

Examples in the literature of art therapy research frequently utilise the case study methodology (Lett, 1993; Quail, 1998; Stanley, 1993), which is discussed in more detail in the following section.

*Case study approach in the art therapy literature*

The *case study approach* is the one most frequently utilised by art therapists. The case study is a description of treatment which often takes the form of a narrative, starting at the beginning of therapy and ending with termination and outcomes. There are a number of variations to the case study method which will be discussed later on in this section.

In his chapter which addresses these issues from the general perspective of counselling, rather than art therapy in particular, John McLeod (1994) traces the origin of the case study back to Freud, reviews the various forms of case study outlined above, and argues that all these methods have some validity, stating that: “case study methods are…well suited to describing and making sense of processes of change” (p. 104). He argues for what he calls “systematic inquiry into individual cases” (p. 103), and suggests that the use of multiple methods for collecting data “offers the promise of getting closer to the ‘whole’ of a case in a way that a single method study could never do” (p. 114).
McLeod (1994) refers to Henry Murray’s (1938) work which sought to combine the depth of psychoanalytic interpretation with the more scientific methods favoured by medicine and psychology. He cites Murray’s recommendations for case study methodology, which include the following: use multiple sources of data; use a team of researchers; carry out a series of case studies; and integrate quantitative and qualitative measures (McLeod, 1994, p. 114). McLeod states that a goal of this method is to allow ‘triangulation’ of data, which means that alternate sources confirm the findings more convincingly than a single source would.

David Aldridge (1994), writing about the arts therapies in general, argues in favour of the single case study research design, in which the researcher presents a single case that is monitored throughout treatment. As Aldridge states, in a single case study design, “each person serves as his or her own control” (p. 335). Case studies can be further broken down to include:

…randomised single-case study designs, often called N=1 studies, single case experimental designs and case study research which may include diary or calendar methods and traditionally includes qualitative data. (Aldridge, 1994, p. 334)

Aldridge (1994) describes randomised single-case designs as focusing on a particular target behaviour (for example, vomiting in the case of bulimia) so that “this target behaviour becomes the baseline measure in an initial period of observation” (p. 335). This behaviour is then closely monitored throughout the treatment phase, during which it is expected to decrease. The “random” aspect is introduced when “treatment courses are randomly assigned” (p. 335).

The single case experimental design is similar but does not include the random element. The base line (pre-treatment) period A is followed by treatment period, B. This is referred to as an AB design (Rosal, 1989). The introduction of further treatment elements (C) makes the design more complex. This may apply to the use of both art therapy and drug treatment, for example, and may be more reflective of clinical practice, particularly

The *narrative case study* represents a further variation of this model, perhaps most familiar to art therapists. The “story” of the treatment is related “without any efforts at quantification of given variables” (Aldridge, 1994, p. 338). Aldridge calls this approach either ‘hypothesis confirming’, when the researcher selects specific parameters for therapeutic change, or “exploratory”, when parameters are not specified ” (Aldridge, 1994, p. 338). One method of collecting data for this type of study is through client diaries which record their progress, thoughts and day-to-day experiences through the treatment period (Ibid). These qualitative methods have also been described as *phenomenological*, since they aim to describe what occurs rather than interpret it.

Aldridge (1994) outlines both the advantages and disadvantages of these research models based on the single case. For example, on the positive side, these single case methodologies are close to therapeutic practice and do not require the recruitment of subjects. There is minimal conflict between therapy and research goals. Also, they may contribute to further research by generating empirical data. (Ibid, p. 340).

It is often argued that single cases are not “generalisable”, which means that the results can not be said to apply to others (Aldridge, 1994, p. 337; McLeod, 1994, pp. 115-116). This is seen as one of the major disadvantages of this type of research. A further disadvantage would be the “the constant problem of finding a common base from which one can build further replicative studies” (Aldridge, 1994, p. 339).

Moreover, Aldridge (1994) argues that qualitative, phenomenological research methods may be powerful if used rigorously by experienced therapists, but fears that they may become an excuse for using no methodology at all by less experienced practitioners, which he sees as being part of a wider problem:
In some ways this received knowledge of “no system” has led to the paucity of research in the creative arts therapies where practitioners have carefully rehearsed the arguments against adopting a scientific method and therapy have done nothing. (Aldridge, 1994, p. 339)

Gilroy (1996) has argued similarly that:

‘Ordinary’ case studies are not enough. Research-based case studies have to have the rigour that comes of detailed and systematised observation and documentation, and have to have the context of an explicit theoretical frame. (p. 55)

Marcia Rosal (1989) makes a similar point, advocating strongly for the single case experimental design to replace the narrative case study in art therapy education, arguing that it is a more objective, rigorous and effective way of evaluating art therapy casework (p. 75).

David Edwards (1999) on the other hand makes a case for the narrative case study. Whilst acknowledging that some case studies, drawn from both the psychotherapy and the art therapy literature, require “healthy scepticism” when reading them, he suggests we should not be too concerned about the perceived lack of objectivity these stories may engender. Rather, he argues for the richness and validity of storytelling in all aspects of our lives, even suggesting the art therapist should interweave facts with fiction and utilise strategies such as plot and suspense in their case studies, both in order to protect the confidentiality of the client, and to make the story more interesting (p. 8).

Edwards (1999) outlines some of the advantages of the narrative case study, including compatibility with our clinical practice, and the ability to treat clients (‘subjects’) as complex individuals rather than objects:

It offers a ‘democratic’ approach to research. That is to say, case studies usually seek to include, rather than exclude, the ‘voice’, personality and other personal attributes of the therapist/researcher and the client. (p. 6)
Research literature on art therapy groups

Gilroy (1995) has documented her rather fruitless search for research on art therapy groups. She cites three British studies, namely those by Liebmann (1981), Nowell-Hall (1987) and Greenwood and Layton (1987; 1991) which describe research projects into art therapy groups, and a handful of American studies (see e.g. Borchers, 1985; Buoye-Allen, 1983) which do likewise. Waller’s (1993) publication on group interactive art therapy includes a chapter on “Curative factors in groups”. Waller lists the “curative factors” identified in group psychotherapy research, and suggests thirteen curative factors for art therapy groups, although the latter are not research-based, but are presumably derived from her clinical experience. These factors were discussed in the literature review in chapter two.

In the new edition to her earlier publication on theme-centred art therapy groups, Liebmann (2004) has added a chapter on art therapy research. This includes a wealth of practical information about the collection of data from art therapy groups. She includes both qualitative and quantitative methodologies, from interviews with research subjects to randomized controlled trials (RCT). She cites one such RCT project which showed that mental health service users who received a combination of brief art therapy groups (12 sessions) and community mental health care, showed significant improvements compared to those receiving only community mental health care (Jones, 2002). However, such examples are rare and this is reflective of the lack of research into art therapy groups, as Gilroy (1995) pointed out a decade ago.

The research into group psychotherapy is well documented (Gilroy, 1995, p. 67), and is far more extensive than research on art therapy groups, as we have already seen. In particular, the work of Yalom (1985) and Bloch and Crouch (1985) provides us with a framework for researching therapeutic factors in groups.
Gilroy’s (1995) research project focused mainly on collecting quantitative or ‘hard’ data into ‘mechanisms of change’ in experiential art therapy student training groups at Goldsmiths College. She describes how she adapted this framework to incorporate ‘soft’ art therapy elements:

A final two questions asked for open comment on the most significant piece of art work and the most significant event in the group…exploring significant events and images through qualitative description in the questionnaire. (p. 70)

The soft or qualitative data she collected is not discussed by Gilroy (1995) in this chapter. However, these two questions she mentions, about the most significant image and the most significant event, were adopted by myself, and formed one of the two main research tools that I utilised in the project, the other being the pre, mid and post questionnaires. The questions are derived from group psychotherapy research (Bloch et al., 1985; Whitely & Collis, 1987; Yalom, 1985), and as such are one of the instruments that have been used to determine the therapeutic factors in groups.

The questions are open-ended, and simply ask for feedback from clients immediately after the group has taken place. It assumes, only, that both events and images within the group will have significance for participants.23

Building on Gilroy’s research, Dudley, Gilroy and Skaife’s (2000) later chapter on this continuing research into experiential art therapy groups marks a move towards a more collaborative approach than Gilroy previously utilised. Much of their chapter is concerned with the specific issues arising from experiential training groups in art therapy education. However the choice of a new methodology, “variously called ‘collaborative inquiry’, ‘new paradigm research’ and ‘experiential participatory research’” (Dudley et al., 2000, p. 180; Reason, 1994) was selected as it seemed more congruent with the group

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23 In the study by Whitely and Collis (1987), the boundaries of the group were extended ‘outwards’ to the boundaries of the therapeutic community, so that the therapeutic factors were also seen to occur outside of the groups, but within the community (for example, in more informal settings).
process, and the non-verbal aspects of the project. The collaboration they describe was with each other as researchers and therapists, and did not include the students they were researching.

**Literature on feminist research**

I shall now consider the literature on feminist research, in which a similar debate between qualitative and quantitative methods has emerged. Caroline Ramazanoglu (2002) states that there is no specific social research methodology which can claim to be feminist, or most appropriate for feminists to use, although she argues that:

> Some feminist researchers, particularly during the 1970’s and 1980’s, developed face-to-face, qualitative and interactive methods as the most appropriate way to produce data on the realities of women’s lives. This approach was specifically taken in opposition to a particular positivist methodological position that assumed quantitative data could best represent reality…It encouraged researchers to give voice to personal, experiential aspects of existence (which dependence on ‘scientific method’ had ignored, or marginalized as ‘subjective knowledge’) and to deconstruct power relations in research. (p. 155)

This passage is interesting as it suggests that feminists and (some) art therapists have had the same or similar misgivings about doing ‘scientific’ or quantitative research, and have had a clear preference for qualitative methods (Burt, 1996). Ramazanoglu (2002) states that more recently however, feminists have suggested they should “avail themselves of whatever techniques are useful for investigating their research questions” (p. 155), and points out that both qualitative and quantitative methods have their advantages and disadvantages.

She does make the following general points in relation to the methodological framework for research: the importance of considering “how to put reflexivity into practice” (p. 160); how to give subjects a voice, when “the language of the researcher tends to dominate interpretation” (p. 161); and the need for explicit interpretive processes (p. 161).
Ramazanoglu (2002) concludes with the notion that feminist research is about transformation as well as understanding, as she says “even a small-scale study has the potential to change the possibilities of people’s lives” (p. 163).

**Literature on client focused research**

The issue of clients’ voices has arisen several times in this overview of research methodologies. I will now consider some of the methods suggested for their inclusion. McLeod (1994) outlines the disadvantage of research which does not include the client’s perspective, stating that “counselors and clients can sometimes diverge greatly in their interpretation of events” (p. 106). He suggests that one way around this has been for the case study to be set up as a collaborative inquiry between therapist and client, although he states that this can only occur after therapy has finished, so that research issues do not affect the therapeutic relationship. McLeod cites the use of tapes of sessions, and clients’ diaries, as alternative ways of incorporating clients’ voices into therapy research (p. 106).

Beresin, Gordon and Herzog (1989) researched the clients’ perspective on recovery in their phenomenological study into recovery from anorexia. The authors combined the use of three clinical instruments and a semi-structured interview with thirteen women who had recovered from anorexia. In the semi-structured interview, the authors asked six questions which they found were neglected in the clinical literature:

1. Do you have any idea what caused your anorexia nervosa?
2. How were you able to recover from anorexia nervosa? What experiences were most helpful and harmful in recovering (both treatment and non-treatment related)?
3. What features of the eating disorder are hardest to change?

24 The measures used were: the Comprehensive Eating Disorders Questionnaire (from Massachusetts General Hospital, Eating Disorders Unit); Eating Disorders Inventory (D.M. Garner, Olmstead, & Polivy, 1983); and Social Adjustment Scale – Self Report (M.M. Weissman & Bothwell, 1976; M.M. Weissman & Prusoff, 1978). (Beresin et al., 1989, p. 107)
4. What did you lose by giving up your anorexia nervosa?
5. Do people ever fully recover from anorexia nervosa? What is left?
6. What advice would you give to others who are suffering from anorexia nervosa? (Beresin et al., 1989, p. 106-107)

Beresin et al (1989, p. 104) developed their study in response to their discovery that previous research did not explore the clients’ experience of recovery from anorexia. Partly this may attributed to the authors’ observation that the DSM-III-R (1987) diagnostic criteria ignored many features, particularly those, (such as social impairment, family problems, and low self esteem) which do not focus specifically on body size and eating (Ibid, p. 104).

Beresin et al (1989) found in summary that:

…the movement towards health entails forming a therapeutic relationship in which the anorexic can identify and express feelings, experience the empathic, non-judgmental understanding of another person, separate from a pathological family system, resolve hostile dependent attachment to parents, assuage primitive guilt, and engage in the trials of adolescent psychosexual development to enter adulthood with the beginnings of a firm, cohesive sense of self. (p. 104)

Interestingly Beresin et al (1989) found that psychotherapy was rated “among the five most helpful and (my italics) five most harmful experiences related to recovery” (p. 114). The difference between these two types of experiences (i.e. negative and positive) seems to boil down to the quality of the therapeutic alliance, as stated in the quote on the findings, above. The authors, citing Bruch (1982), suggest that it is most important for therapists to avoid “inflexible adherence to one’s own theory” (Beresin et al., 1989, p. 115) since they see this as an unhelpful parallel to “the (clients’) experience of parents’ dictating covertly or explicitly how to appear, feel and think” (Ibid, p. 115).

Becky Thompson’s (1994) phenomenological research study mentioned in chapter four has a client focus, but is discussed in the following section as it also includes a feminist perspective.
Thompson’s (1994, p. 4) research project *A hunger so wide and so deep*, involved in-depth interviews with eighteen American women with various racial backgrounds, including African-American, Latina (Hispanic) and white women. Two thirds of the women had had eating problems for over half their lives.

Thompson’s (1994) perspective is feminist, and she cites this as a reason for not using the diagnostic term ‘eating disorders’, since she sees diagnosis as an example of patriarchy pathologising women’s adaptive behaviours. In other words, “for many women, bingeing, purging and dieting begin as creative coping mechanisms in highly disordered circumstances” (p. 6). An example of these disordered circumstances, according to Thompson, is the experience of sexual abuse and other trauma which can lead to Post Traumatic Stress Disorder (PTSD). Thompson states that PTSD is one of the few diagnostic categories which acknowledges the impact of the environment on the individual (see note 21 in Thompson, 1994, p. 139), and argues that in many cases, eating problems may be trauma-based rather than appearance-based ‘disorders’ (pp. 14-16).

Thompson (1994) is also interested in exploring the impact of racism on black and Latina women. She found that some women were unable to conceptualise their body image since they did not have a sense of ownership of their body, due to the impact of slavery (pp. 16-17). In addition, women who experience dissociation, (a symptom of PTSD when the individual has the sense of being separated from her body as a result of body-based trauma), may similarly have difficulty developing or maintaining a healthy body-image (p. 18).
With regard to therapy, as we have discussed in chapter four, many of Thompson’s (1994) research participants did not actively seek therapy for their eating problems\(^{25}\), but the majority of them experienced it as helpful. She summarises their requirements for therapy as follows:

The combination of skills they sought (in a therapist) included racial and cultural sensitivity and experience in working with lesbians and people who have been traumatized. (p. 115)

Again we see the feminist therapist defined as a practitioner with a wide social and cultural view, and with the clinical experience to meet the specific needs of this diverse population.

We are also challenged by Thompson’s (1994) study to see a variety of experiences as therapeutic, for example: affirming racial and sexual identities; coming out as a lesbian; leaving family or partners; and political activism (p. 118). As Thompson (1994) states, this may require flexibility and commitment on the part of the therapist:

A therapist’s ability to support a multi-faceted approach to healing often depends on willingness to build multi-cultural bridges, both personally and professionally. (p. 128)

Black and Symes (1998) used a combination of qualitative and quantitative methods to research feminist therapy groups for women with eating issues. They state that “in keeping with feminist practice a central focus has been understanding and recording women’s experiences and stories” (p. 28). Their methodologies included participant questionnaires, the Eating Disorders Inventory, informal recording of group sessions, and professional reflections.

On the question of measuring recovery, Black and Symes (1998) focus on the underlying issues as well as on behaviours related to eating and food. These underlying issues

\(^{25}\) Thompson (1994) sees this as an economic issue in the USA, as health insurance is a requirement for inpatient treatment and hospital based care, and many of the women in her study would not have been able to afford this (p. 115-116).
include self-esteem, autonomy and the identification of feelings. The authors refer to Peters and Fallon’s (1994) chapter which proposes the following parameters for change:

1. Denial to reality – viewing the eating disorder as a problem rather than the solution;
2. Alienation to connection – reaching out to other people; and
3. Passivity to personal power – moving beyond being a victim. (p. 354)

A significant finding of Black and Symes (1998, p. 33) is that women group participants who also had individual counselling during the period of group attendance did significantly better than those who did not, a finding that was taken into account in this project.

In her chapter *Use of the self in qualitative research*, Estelle King (1996) argues that feminist research has “highlighted the centrality of affectivity” (p. 176) seeing it as a critical part of the “social construction of the research encounter and of the production of knowledge” (p. 176). King calls affectivity [“feelings, biases and personal peccadilloes” (p. 176)] a “dimension of reflexivity” which aims to “redress the power inequalities between the researcher and the researched, in order to construct meaning” (p. 176):

Opening up the structures and operations that underlie our research and examining how we as researchers are an integral part of the data will amplify rather than restrict the voices of the participants. (p. 176)

*Literature on feminist art therapy research*

This section looks at the broader question of feminist art therapy research. The following section will return to the specific topic of research on art therapy with women eating issues.
In one of the first art therapy papers to address gender issues, Harriet Wadeson (1989) develops Carol Gilligan’s (1982) hypothesis of ‘masculine’ and ‘feminine’ modes of behaviour, and applies it to the art therapy profession, with particular reference to research methodologies. In Gilligan’s schema, the masculine mode is defined as being concerned with reasoning and science, whereas the feminine mode is concerned with connection and caring (p. 328).

Whilst this schema results in a rather simplified and polarised view of what is masculine and feminine, Wadeson (1989) suggests it may shed some light on the paradoxical forces that shape art therapy research. She argues that whilst the female dominated profession of art therapy still submits to pressure to conform to the more masculine demands for “separating, cataloging and quantifying” in its research methods, it is not doing itself justice or operating from its strengths:

As we try to apply these methods to research in our fields, we find that it is difficult to assess art expression by such a reductionist approach…the impact of a painting cannot be reduced to the measurement of its graphic characteristics. (p. 329)

Wadeson (1989) states that rather, “it is our unique creative connection to the people we serve through the arts that defines our identity” (p. 329), which involves utilising the feminine mode of “connectedness and creativity” (p. 329) in our choice of research methodologies.

Marlene Talbott-Green (1989) makes a similar point her article, which appears in the same issue of The Arts in Psychotherapy as Wadeson’s (1989) paper. She argues that art therapy, like feminist therapy, is perceived by mainstream mental health professionals as theoretically undeveloped, therapeutically and methodologically questionable, and with few claims to validity or reliability (p. 253). Talbott-Green suggests several reasons for

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26 Wadeson defines these modes as “male” and “female”, but I find that masculine and feminine more useful terms, as they are intended to describe behavioural styles not individual males and females.
this assertion, including “exclusive editorial policies” and “sex bias in research” (p. 253). She argues that:

…creative arts therapists must try to elicit and study the internal experiences of women, their perceptions, emotions, interactions, and values, and to present these, and not theoretical interpretations, as their primary research data. (p. 260)

Helene Burt (1996) in her paper *Beyond practice; a postmodern feminist perspective on art therapy research*, suggests that “art therapy can hold a claim to being the field which has paid the least attention to feminism” (p. 12). This is despite the fact that the vast majority of art therapists27 are female (Burt, 1996, 1997; Joyce, 1997). In addressing the issue of art therapy research, Burt (1996) states that:

A feminist standpoint researcher would question and rethink from a women’s perspective, the traditional models of development, accepted norms of mental health, and other gender-biased theoretical assumptions. (p. 13)

Burt (1996) also argues that “there has always been a pervasive assumption among art therapists that we need to do more quantitative research in order to further the aims of our profession” (p. 13)28. She suggests that a feminist research methodology would consider female development using frameworks such as *relational theory*, and that a postmodern feminist perspective also needs to take into account differences between women, such as race and sexuality (p. 13).

Burt (1996) argues for reflexivity; researchers need to be clear about their biases and assumptions (p. 14). She challenges the use of diagnostic tools such as the Diagnostic Drawing Series (DDS) (Cohen, Mills, & Kijak, 1994) on the grounds that it is based on “a white, middle-class, heterosexual male definition of what is normal” (p. 15), namely the DSM III-R29 (1987), and also, therefore, according to Burt, psychiatry and psychoanalysis.

27 Eighty six percent of the American Art Therapy Association members in 1994 were female (La Brie & Rosa, 1994).
28 Although this would hardly be true of British art therapists. It is likely Burt is referring specifically to North American art therapists here.
To illustrate her point about bias in DSM III-R, Burt (1996; 1997) uses the example of Borderline Personality Disorder, (BPD) which she argues is a diagnosis usually ascribed to women. She compares the features of BPD with the criteria for healthy women (as opposed to healthy men) as determined by a group of therapists, and finds many parallels, leading her to hypothesise that gender bias is indeed a part of diagnosis (p. 15). In another example, still in relation to BPD, Burt highlights the “mother blaming” focus on the early stages of the mother-child relationship, in developmental theories adopted uncritically by psychiatry and psychoanalysis. This focus has, according to Burt, resulted in the father-child relationship, and traumatic events such as sexual abuse, being largely ignored (p. 16) with these clients.

Burt (1996) gives her rationale for feminist researchers preferring qualitative research, stating that it has an emphasis on: listening; learning form the individual participants, and using the actual words of the participants whose “voices were silenced in previous research” (p. 16). Burt includes in her paper the narrative of a client, Isabella, whose art therapy formed part of Burt’s doctoral thesis, and who says “I need to show people visually what happened to me” (p. 18). Burt questions the assumption that quantitative research is objective and scientific, on the basis that such methodologies generally do not acknowledge the biases which all researchers are influenced by. She concludes however that:

…neither methodology is more suited to art therapy research than the other. Feminist art therapy research must emerge from an awareness of the power differential between the genders. (p. 17)

In other words, according to Burt, “feminist research is defined …by the type of questions asked and how they are asked” (p. 17) rather than by the type of methodology used.
Research literature on art therapy with women with eating issues

As previously noted, Michele Wood (1996) has commented in her survey of the British art therapy literature, on the lack of art therapy research into this client population. As she states, and in common with a great deal of art therapy literature (see e.g. Gilroy, 1995, p. 67) the eating issues literature is concerned with the description of clinical work rather than the evaluation of its effectiveness (M. Wood, 1996, p. 18). The only exceptions cited by Wood are an unpublished paper into a research project at Goldsmiths College by Waller in 1983, [subsequently written up in part by June Murphy (1984)] and Luzzatto’s (1994b) case study using short term individual art therapy in which a three year follow up confirmed that the changes made by her male client had been maintained.

American social worker and art therapist, Andrea Morenoff and Barbara Sobol (1989), describe a long term clinical intervention with bulimic women. Art therapy tasks were introduced once every six weeks into therapy groups which met weekly. The authors state that clients who stayed in treatment for 3-5 years were successful, and this was determined by a 70% reduction in bulimic symptoms, as well as by “lifestyle changes that reflected improved self-integration and higher ego-functioning” (p. 166). It is not clear how these changes were measured, as the authors’ focus is on therapy rather than research. It is also not clear, since they adopted a multi-disciplinary approach, how instrumental a component the art therapy was in the success of the overall program.

Two significant publications have emerged since Wood (1996) wrote her review of art therapy literature with this client group. Canadian art therapist Susan Makin (2000), as with many others, is largely descriptive of practice rather than concerned with research. Her final chapter, however, touches on the issue of the effectiveness of art therapy with this population. She states that these patients are often drawn towards “arts and crafts activities” (Makin, 2000, p. 191). She notes anecdotally that many clients take up
creative activities in their recovery from eating issues (p. 193), a point that was also made by Garrett (1998), as previously discussed in chapter five, and Matto (1997).

Makin agrees with Murphy, (1984) that art therapy is usually part of an overall treatment package rather than an isolated intervention, which can make evaluation difficult. However, Makin does take every opportunity to let her clients’ speak. As she says:

The magic of art therapy happens for me in what patients say, unprompted, about their experience or product, or both. They talk of how the session worked or didn’t work for them, for reasons about which I may or may not have thought. The patients, creators of incredible artifacts, hold the key to them, and are the only ones who can provide access to their worlds and accompanying particularities. (Makin, 2000, p. 191)

Makin (2000) makes a plea for art therapists to use jargon-free language, and expresses her concern that many clinicians “put themselves on pedestals, particularly when giving case presentations” (p. 195), mainly by solely using their own voices in the narrative. To counteract this, she argues for the inclusion of clients’ voices on these occasions, which will she believes bring us “closer to the truth and effective treatment” (Ibid).

In her recent publication, Mury Rabin (2003) has documented a research project she undertook over many years with women with eating issues. She utilised a methodology which compared the participants’ responses to a range of art-based and non art-based tasks, which were then repeated, over a period of time. In this way she measured their individual progress “herself to herself” (p. 149). Despite the fact that all the women were seen individually, she comments on the similarity between them, “both in their pictures and words that echo each other’s perceptions and emotions” (Ibid).

Rabin (2003) describes a structured research project which seems to contain elements of both qualitative and quantitative inquiry. This involved the administration of a specific battery of art therapy and other tasks were then repeated sometime later in order to compare them with the original, and monitor for changes which could indicate improvement. In this sense, the tasks could seem to be designed more for the purposes of
the researcher than the client. However, Rabin claims this was clinically useful as “the process of repeating what was the same issue, i.e., self-concept, over and over, overcame their denial and revealed their truth” (p. 149). She like Makin gives the clients many opportunities to “speak” in her narrative.

Rabin (2003) does not focus specifically on gender in her research, except to highlight the lack of information on males with eating issues (p. 14). She identifies the gaps in treatment as being addressed by her tasks which focus on the self-concept (p. 10). A fundamental difference in her approach is seeing eating disorders as an addiction30. Rabin does not include a literature review or detailed discussion of her methodology framework.

Whilst acknowledging the difficulty of incorporating art therapy into traditional research methods, Rabin (2003) hopes to see “expressive art being accepted as reliable scientific evidence in its own right” (p. 149) in the future. Her vision includes a cross-fertilisation of medical and art therapy research methodology (p. 150), involving “co-operative methods on the part of the art therapist and the more traditionally oriented researcher” (p. 149). These methods are not spelled out, however.

There is still, almost ten years on from Wood (1996), a dearth of published research into art therapy with women with eating issues. My project was carried out in 2000, and I had not seen Makin’s (2000) book until after it was completed. Her main contribution, applied retrospectively, is her plea for the inclusion of clients’ voices in art therapy narratives, which would also include research, which was coincidentally an issue I was most keen to address. In addition, she suggests that the use of art in recovery may be an avenue worthy of further inquiry.

30 This approach has not been widely discussed in the clinical art therapy literature. Its treatment, that of twelve step support groups such as Overeaters Anonymous, is mentioned by seven of Thompson’s (1994) subjects as being helpful, in her inter-racial, phenomenological study of women with eating problems.
Appearing three years after my project was implemented, Rabin’s (2003) main contribution is her adherence to a regime of specified tasks over a long period, which demonstrates the value of using individual progress as the benchmark for successful treatment and recovery, which I also adopted in my pre-, mid and post- questionnaires. In fact, this may be the only way to research, as the difficulty of comparing art work for example may be too problematic and has yet to be validated, as we shall see below.

_Feminist art therapy with women with eating issues_

As we might expect, given the mainstream void, there is even less feminist research into art therapy with women with eating issues. In a rare example, Australian social workers Black and Symes (1998) included their findings on the use of ‘creative arts strategies’ in their feminist therapy groups for women with eating issues as part of a broader study. The authors used a number of data collection methods including qualitative and quantitative methodologies (p. 29). These methods included participant questionnaires and the Eating Disorders Inventory (E.D.I.)\(^{31}\). In relation to use of these creative arts strategies, (which were not utilised by art therapists, but by non-specified group facilitators or social workers), they found that:

> Arts strategies provide an alternative medium of communication for women who are used to communicating through their disordered relationship with food and their body. (Black et al., 1998, p. 46)

Ball and Norman’s (1996, p. 57) fourteen week feminist art therapy group for women with “issues around food” was evaluated by the group facilitators, although the specific findings of this evaluation are not stated. Ball and Norman comment on the value of art therapy with these clients due to their difficulties with verbal expression, and outline several of the themes which arose in their work (1996, p. 56). They explain their general

\(^{31}\) Black and Symes (1998) state that:

The E.D.I. is a widely recognised inventory for differentiating between those who meet the criteria for having an eating disorder and those who do not. However it is not a diagnostic tool and further assessment is required to clinically diagnose and eating disorder. (p. 29)
approach which is non-directive and non-interpretive. There is no information given about what happened in that particular group, however, or whether the participants found it beneficial. This seems to be a result of their strict confidentiality policy which does not allow for any records to be kept about individual participants (1996, p. 54), however it is unfortunate that the authors are so reticent about their participants’ experiences, both positive and negative.

The organisation which Ball and Norman (1996) were working in, the Northern Initiative on Women and Eating (NIWE), has been extensively evaluated (Webb, 1993). Referring to Webb’s report, Ball and Norman (1996) state that “in the main, users of the service were overwhelmingly positive and said that they would recommend the service” (1996, p. 58). They also offer a list of recommendations for workers in this field (pp. 58-60). These include: use of a non-medical and non-behavioural model including avoidance of diagnostic labelling; facilitators’ role is collaborative rather than ‘expert’; co-facilitation across disciplines; regular supervision and awareness of own issues in relation to eating and food; self-referral service; and adopting the framework of a “continuum of need” so that a variety of services may be offered.

**Ethical concerns regarding research in the art therapy literature**

Several art therapists have expressed concerns about some of the ethical aspects of art therapy research. American art therapist Maralynn Hagood (1990), for example, refers to concerns raised by Nowell Hall (1984) in her master’s thesis about “ethical problems in controlled studies, although she does not state what those ethical issues are” (Hagood, 1990, p. 78). Possibly Nowell Hall was referring to the fact that in controlled studies, some clients may not receive any treatment if they are assigned to the control group, although this is speculation on my part. Hagood (1990) also refers to Joan Woddis’ (1986) concerns that American art therapists “are contributing to the dehumanising
qualities of the medical model” (Hagood, 1990, p. 78) when they focus narrowly on using artworks produced in art therapy as a diagnostic tool.

Visual research

Gillian Rose (2001) addresses an area which, although she does not specifically mention images produced in art therapy, is very pertinent to the way in which art therapists and others think and write about art, namely the use of images in research, particularly in regard to the articulation of power relations (p. 202).

Rose (2001) argues that a critical approach to images needs to do the following three things: it “takes images seriously”; “thinks about the social conditions and effects of visual objects”; and “considers your own way of looking at images” (reflexivity) (pp. 15-16). Rose identifies three “sites” and three “modalities” for looking at images. The sites are: the production of the image, the image itself, and the audience. The modalities, which are cross referenced with the sites, are: the technological, the compositional and the social. By considering all these factors, Rose suggests, the researcher can do most justice to the image.

Rose (2001) reviews a number of methodologies which have been used in visual research, which she briefly outlines as follows:

1. **Compositional interpretation** – pays attention to high Art, is concerned with attribution of art works to artists, schools and styles, and of judging quality. This methodology is derived from art history (Rose, 2001, pp. 33-34).
2. **Content analysis** – developed as a social science tool to quantify and analyse the content of a large number of images which are related in some way (Ibid, p. 54).
3. **Semiology** – often used in the analysis of advertising - “entails the deployment of a highly refined set of concepts which produce detailed accounts of the exact ways the meanings of an image are produced through that image” (Ibid, p. 70).
4. **Psychoanalysis** – particularly feminist Lacanians – use psychoanalysis to understand the production of sexual difference, for example, in images, especially in film. “They pay close attention to these visual images and are centrally concerned with their social effects: the ways they produce particular
spectating positions that are differentially sexualized and empowered” (Ibid, p. 100).

5. **Discourse analysis I** – “interested in how images (and texts) construct accounts of the social world” (Ibid, p. 140) – the rhetoric of persuasion.

6. **Discourse analysis II** – for example, the museum or art gallery is studied as a public space which contains images - “tends to pay more attention to the practices of institutions...explicitly concerned with issues of power, regimes of truth, institutions and technologies” (Ibid, p. 140).

Rose (2001) states that none of the six methodologies she identifies can address all the possible sites and modalities, and that therefore a combination of methods may be required (p. 202). Although Rose is not specifically concerned with images produced in art therapy, her model may well prove useful in giving greater weight to the image in art therapy research, by suggesting the multiple ways in which the image in art therapy may be viewed and understood.

**Summary of research methodologies**

The previous section reviewed a number of research methodologies which were considered, and which informed the research project described in the following chapter. The following methods were chosen to form part of the research approach: the case study model; the use of and focus on the participants’ art work; the qualitative approach, which included the voices of the participants as well as their images; a feminist perspective, which included an awareness of gender, power relations and reflexivity; and an awareness and appreciation of the art therapy research tradition, as well as a wish to break free from that tradition. By selecting these methodologies or approaches, I was hoping to address some of the problems I had identified earlier in the art therapy literature.
6.3 Socio-cultural climate and art therapy

At the time of writing, art therapy as a specific discipline is still relatively unknown in Australia. Despite its acceptance and establishment in the UK, North America and Europe, in Australia art therapy (conducted by a registered art therapist) is not usually available for clients, either in the health service or non-government (community) services. Art therapy positions in Australia are relatively rare, or are just beginning to be established, and art therapy education is also still in the early stages of development. A Masters in art therapy course has just been introduced in Brisbane (2004). Such courses have been previously established in Sydney, Melbourne and Perth in the past 15 years. Therefore, the employment of a registered art therapist to co-facilitate group work is rare or very unusual.

Indeed it became clear as the project progressed that the therapeutic bias of the group was also a marked departure from the usual type of group offered by the service. Groups offered by the service generally had a psycho-educational and supportive function, rather than being seen as therapeutic, and the individual work offered to women accessing the service was referred to as ‘counselling’ rather than ‘therapy’.

Predominance of biomedical model in Australia

Forms of psychotherapy such as art therapy represent an alternative to the mainstream, biomedical approach to eating issues, which predominates in psychiatric hospitals (McDermott et al., 2002, p. 318). This may be particularly true in Australia. In their historical overview of psychiatry in Australia, Gilroy and Hanna (1998, p. 272) comment on the dominance of the medical model in psychiatry, and the relative lack of influence
on psychiatry of psychodynamic concepts, as compared to Britain, North America and Europe. This biomedical dominance can result in a lack of support for methods such as art therapy (or indeed psychotherapy), which may be viewed as ‘unscientific’, invalid, insignificant or otherwise suspiciously ‘alternative’.

The bias against psychodynamic approaches also seems to have filtered through into other disciplines such as social work, at least in South East Queensland, based entirely on my own observations. This bias seems to derive from a backlash against a perception of Freudian misogyny, or more generally from an underlying assumption that ‘therapy’ involves something unpleasant being ‘done to’ the client, with the fear that it would not benefit them, or may well be harmful: concepts which are not supported by clinical evidence (Asay et al., 2003).

This assumption is demonstrated by the philosophy of a variety of welfare agencies working within a social work and feminist framework. In other words, because of its psychodynamic roots, art therapy may be viewed with suspicion from both the ‘establishment’ of psychiatry (not to mention the ‘otherness’ of art in a medical context), and from the ‘alternative’ model of (feminist) social work practice.

My goal in developing this project was to demonstrate the validity of art therapy within this challenging climate. I found that despite the above, art therapy was generally seen in a positive light by individuals working within social work frameworks, perhaps because the psychodynamic roots were not fully understood, and the focus was more on the ‘art’ than the underlying framework for ‘therapy’. This finding is supported by Gilroy and Hanna (1998), who suggest “it could be that art therapy will be in the vanguard of the acceptance and inclusion of dynamically-based treatment approaches in Australian psychiatry” (p. 272).
My approach, moreover, was not to work purely from this psychodynamic premise. Rather, my aim was to develop a framework for art therapy with different theoretical orientations than the ‘traditional’ psychoanalytic approach. I hope to show how art therapy can offer an alternative/complementary framework for working with eating issues, which can work alongside more established (medical or psychoanalytic) approaches.

6.4 An alternative model for art therapy

My research project design and theoretical approach was informed by the gaps that I found in the literature, as outlined in chapter two. This work, like many of those I have read, attempts to address the topic of art therapy and eating issues from the perspective of clinical art therapy practice. I have attempted to address socio-cultural issues in chapter three. I have incorporated the voices and images of the women who participated in the research in a variety of ways, most significantly in the use of data collection which encourages a reflective commentary from the women on their own participation, and which incorporates their art work as data as well. I have linked my art therapy approach to a range of theoretical frameworks including feminist and solution focused approaches in addition to psychodynamic theory.

This approach can be further contextualised, as it represents a conscious choice to work outside of the mainstream, biomedical approach, which as we have seen, predominates in Australian hospitals, and within a feminist, community-based organisational structure.

Finding a feminist organisation in which to carry out the project, however, was problematic. My first approach to an organisation in South East Queensland which specialized in facilitating groups for women with eating issues was ultimately
unsuccessful. There was at that time no scope to develop a model which differed from the one already being utilised. This was despite the fact that the organisation had a very similar theoretical orientation to me, and which frequently used creative activities in their therapeutic groups (although they did not employ an art therapist). The second organisation which I approached gave a more promising, positive response, and this was backed up by their eventual decision to pay me for the group work undertaken.

The context of therapy

The project I undertook was to design, conduct and document a short-term community based art therapy group for women with eating issues. The group was conducted in a Women’s Health Centre in Ipswich, a provincial town South West of Brisbane, Queensland. The research project was investigated using qualitative research methods, which will be discussed in more detail in the second part of this chapter. These methods included opportunities for the participants to give regular written feedback on the art therapy process, which would form the main component of the research material, alongside their artwork, and my own process notes.

Theoretical frameworks

The overall approach of the project was to integrate elements from art therapy and feminist group work practice, incorporating structured art therapy activities, and a variety of other methods such as journalling, group discussion, and use of resources to provide information on eating issues. The theoretical frameworks informing the facilitators

32 In an early document produced by the organisation in question, Isis, Group work with women with eating disorders, (Black et al., 1998), the authors argue that a feminist approach, which “is denoted by creative processes, flexibility, consultation and input from participants” supports the use of “creative arts processes” in groups (p. 17). Later on they state that “creative arts activities are an integral component of the group work process…(they) offer women with eating disorders another medium through which to express themselves, rather than through their relationship with food and their bodies” (p. 43).
included psychodynamic art therapy, and feminist therapy, as well as elements of cognitive behavioural therapy (CBT) and solution-focused therapy, which were introduced and outlined in the previous chapter.

**Directive, theme-centred art therapy group**

The art therapy group was therefore not conceived in a ‘classical’ psychoanalytic art therapy framework, which would be largely unstructured and non-directive (D. Waller, 1993). In other words, the ‘traditional’ psychoanalytic style of art therapy groups commonly described in the literature, especially in Britain, is one in which themes emerge spontaneously through the group process, and are not pre-planned and pre-structured (McNeilly, 1984; Rust, 1992; D. Waller, 1993; M. Wood, 2000). These groups, however, usually run for longer than ten weeks, and this enables a stronger group process to develop over time. As Waller (1993) suggests, structured, theme-centred groups are more suited to short term “outpatient” groups. In this short-term group, the facilitators played a more active and directive role, both in planning and actively providing structure for the sessions.

**Role of facilitators**

The role of the facilitators was not to present a ‘blank screen’ to the group, but to participate to an appropriate degree, and to provide positive role models for the group. On the ‘blank screen’ approach, Paul Gibney (1995) states that “the danger of working that way is its more about keeping the therapist safe than it is about facilitating the client’s process” (p. 37).

The influence of feminist therapy was perhaps seen most strongly in the therapist role. The method of delivery adopted by myself and Sandra, my co-facilitator, was an open,
inclusive, transparent process. As discussed in chapter four, feminist therapists have frequently commented on the therapists’ role, seeing it as perhaps the most significant aspect of feminist therapy. Black and Symes (1998) stress the importance of listening to clients:

A feminist approach to understanding eating disorders has arisen out of listening to women and how they understand their experience of an eating disorder…if practitioners are to gain any real insight or understanding about the experiences of women with eating disorders it would seem obvious that there is a need to ask women themselves. (p. 10)

In an art therapy context, looking carefully at the clients’ artwork might be as important as listening to their voices, as art is often described as an alternative means of communication to verbal expression.

Tolman and Debold (1994) suggest that the role of feminist therapists is to provide “example, support, critical perspectives and company of adult women” (p. 313). Features of the feminist therapist role, according to Kearney-Cooke (1991) include the following:

The approach described…challenges the therapist to step out of the role of a silent expert and to struggle actively with the patient…it challenges therapists to be clear about who they are and how they relate to others. It encourages therapists to be aware of their own struggles with shape and weight…It demands an understanding of the cultural context in which an eating disordered patient’s struggle takes place, as well as the provision of a relationship where the patient can clearly experience herself as having an impact on others. (p. 316)

In addition, feminist therapists need to combine a therapeutic approach with a political and gender analysis – as Eichenbaum and Orbach (1983) have suggested:

As feminist psychotherapists we bring in our political and personal attitudes, biases and values to the work we do. We hear what our clients say with a particular ear, no more special in its peculiarity than other therapists, but with a stated bias that sees women as the oppressed sex within patriarchy. (p. 69)

Our goal then as therapists was to be clear about the group’s goals and purpose, and about our roles and agenda within it. My dual role, being that of art therapist/researcher, was different from my more familiar role as art therapist. I needed to listen to the clients and to look carefully at their artwork. I needed to be very clear and explicit about the
research project, and what this meant, as well as being clear about our attitudes towards eating issues in particular and women’s issues in general. Part of this was already understood from the location of the group within a feminist organisation.

I have described the social context of the art therapy project, and the facilitator’s roles. I shall now describe the research instruments I developed for this project, and the process of planning for this intervention.

**Design of research instruments**

The approach I adopted is based on the case study methodology outlined by various art therapists in the previous section of this chapter, with additional methods as outlined above, which perhaps falls somewhere between the narrative case study and the experimental case study design.

The following section outlines the research tools I used for this project. These consisted of two main instruments, which can be found in the appendix of this thesis. The first was a pre, mid and post group questionnaire, to be completed by the participants at the beginning, middle and end of the art therapy sessions. The second was a weekly questionnaire which asked participants to complete two open ended questions about what had occurred in the session that week. The aim of the first process was to provide a benchmark from which to monitor any changes that occurred during the art therapy sessions, as most of the questions were basically repeated at each point of completion.

In some respects (although not entirely) the pre, mid and post questionnaires may be said to provide an experimental element to the research, as they do provide for the measurement of change, particularly in the use of scaling questions, and in the use of questions repeated at strategic points in the therapy. The questionnaires were designed to
elicit specific thoughts and feelings from the participants at different stages in the therapy process, in order to determine whether any changes were taking place. These thoughts and feelings specifically addressed their eating issue and body image and also sought feedback on their experience of the group.

All the research tools utilized were developed specifically for the group. The pre, mid and post questionnaires I used were written by myself and were not the same as a standardized test (which might be viewed as a more ‘rigorous’ tool with more relevance to other clients and settings). This was a deliberate choice on my part as originally I had considered using the E.D.I. (Eating Disorders Inventory) (D.M. Garner et al., 1983) as my research instrument. However, this basically diagnostic tool did not seem to ‘fit’ with my feminist, non-medical approach. I was not interested in finding an appropriate label for the participants, but was more interested in their own definitions of their difficulties. Undoubtedly this decision had its advantages and disadvantages, but I think the choice I made was more congruent with the overall project.

The second process was to provide an ongoing ‘snapshot’ of the sessions from the clients’ perspective, both in terms of their experience of the group as a whole and in terms of their response to the imagery generated in the group. The schedule of two questions completed weekly asked the women to nominate the “most significant event” in the group each week, as well as the “most significant image”. The first question has been used before in qualitative research into the efficacy of group psychotherapy (Bloch et al., 1985; Whitely et al., 1987), and the second has been adapted for use in art therapy group research (Gilroy, 1995).

Both the research instruments provided a platform for continuous feedback from the participants to the facilitators, which would inform both the research and the therapeutic process itself. The premise for this is a collaborative research model, in which participants are seen as co-researchers as well as ‘subjects’.
In addition, the participants’ art work formed an important part of the research material collected. This art work is included in the case study and can therefore be seen to contextualize the comments made by the participants in relation to the images.

**Group planning and setting up**

The facilitators, Sandra and I, met several times before the groups began, to discuss and plan the group program. The social worker, Sandra, had several clients with eating issues, whom she saw for individual counselling, and she was aware that their needs could be met in a different way through their participation in a group.

Therefore the need for a group was already identified by Sandra, and this coincided with my request to the agency to support the eating issues research project. The fact that Sandra and myself had previously worked together at a different agency, and this had been a positive working relationship, meant that the process of planning and co-facilitation was smooth and unproblematic. Both workers had a similar theoretical stance on eating issues, and both wished to expand their knowledge and experience in this area. In addition, both were committed to the use of art therapy as the primary modality of the group.

Once the initial meetings had taken place, a starting date was proposed. The program was advertised in the agency newsletter and through other local networks including GP’s surgeries. Although this resulted in some enquiries, in the event no referrals came from outside the agency. Several of the women who were in individual counselling with Sandra came forward for the group. These women were interviewed individually by both facilitators. As a result of this process, four women were identified as being interested in participating in the group, and were willing also to participate in the research project.
Participation of clients

It was clear at this stage that four was not a large number of women to participate in the group. Generally speaking, a minimum of about six would be preferable, given that some may drop out or be absent occasionally. Less than six would perhaps not be enough to create the optimum number in a group for psychodynamic processes to develop, which would ‘carry’ the participants through the group program. However, we decided to go ahead with the groups, since they had been advertised, and there were at that stage four women recognising their need for such a group. In part, the decision to go ahead was based on the difficulty these women had in coming to the point of recognising they could benefit from such a group, and therefore “capturing” a large group may prove very difficult. Having gone through this process of self-identification and acceptance, which in all cases was a painful process in itself, it would have seemed inappropriate to have decided not to continue due to the low numbers.

In any event, only two of the four women attended the groups. This obviously intensified all the above issues even further, particularly with regard to the agency, which needed to justify the provision of cost-effective services to the funding body. The rationale for paying two facilitators to run a group for two women was a difficult one to justify. This situation created an underlying tension between the facilitators and the agency, due to our decision to go ahead with the group. As a result of this tension, there was some reluctance about paying me, which was eventually resolved, and there was also some “awkwardness” around the acceptance of the group from some other staff members.

I was aware that the numbers would be an issue for the research, as they were for the agency. However, both facilitators felt ethically bound to run the group, in recognition of the women who had put themselves forward. It is clear to me that the groups did not go
ahead because of the research, but in spite of it. This participation factor had a dramatic
effect on the research project, which was originally conceived as exploring the
effectiveness of a group approach. Clearly the intervention could not really be described
as a group, which would require a larger number of participants. One option would have
been to run the groups again, perhaps at a different agency. However, in the end, and
partly due to the difficulties I had initially in finding a venue to run the project, I decided
to progress with the material produced by the two participants. I have treated the project
as a case study of two individuals, rather than as a group intervention. Where I use the
word “group” in later discussion, it is based on the understanding that this both was and
was not a group.

Additional research activities

In addition to the material presented in relation to the Ipswich art therapy intervention, I
have participated in many other activities, which have informed my approach. In a
sense the breadth of my inquiry is a reflection of the vastness of the topic, which seems to
extend itself from the very fabric of our society from which it emanates. This is in
contrast to the very specific nature of the intervention, and the fact that the material I
gained was from only two women who participated in the project. My approach to this
area has been informed by the participants but also to the following.

I have networked with other agencies, both in the UK and in Australia, which work with
women with eating issues, especially those, which use a feminist approach. This has
involved direct approaches to agencies, asking to participate or to gain information. In
one case I attended weekly staff meetings, and hoped to be able to run my group there,
but this was rejected by the agency. Also, I have written to individuals who have written
on the topic, to extend my knowledge of what they have written. I have attended training
sessions, for example a workshop and presentation by Ann Kearney-Cooke, as I was
aware of her feminist approach. I also attended a seminar by Scott Miller, to learn more about his approach to therapeutic effectiveness, and a digital photography workshop to facilitate better images.

I have continued to work as an art therapist with individual women and girls with eating issues, both in private practice, and in a hospital-based Child and Youth Mental Health Service, a position I gained since beginning this research. This experience has both confirmed and challenged my ideas about working with the medical model. I have talked to parents of anorexic girls, including women who themselves used to have an eating issue. I have brought my awareness of the topic into my work with other clients, and in my general interactions with colleagues and friends, noticing their body size and self-awareness, and wondering about the times when it was and was not talked about, and my responses to this. I have also worked on my own eating issues, which although not clinically significant, have been nudging insistently into my awareness for the duration of this research project. I have used my artwork, my clinical supervision and my writing to further explore these issues: from a research-perspective, culturally and from an emotional perspective.

This chapter has described the methodology that was developed for this project. The following chapter will describe the dual case study in closer detail.
Chapter seven: Case study

7.1 Introduction to dual case study

The previous chapter described the methodology that was developed for this case study. This chapter describes the art therapy intervention, images created and comments by the participants. The project I undertook was to develop a short-term art therapy group for women with eating issues in a non-medical, community context. The group was conducted at Ipswich Women’s Health Centre, in a provincial town South West of Brisbane, Queensland Australia, in 2000. The project started in March 2000, and continued for ten sessions.

The two case study participants will be introduced at this point. I have changed their names in order to preserve their anonymity.

Anne: The first participant, ‘Anne’, is a woman in her late thirties with a chronic eating issue of 13 years duration. Anne appears to be underweight, and also identifies problems with alcohol, anxiety and obsessive compulsive disorder, or OCD. She may meet the diagnostic criteria for anorexia although this was not assessed. She is not weighed for this study. She described her typical daily food intake as breakfast, an apple for lunch and yoghurt for dinner. Anne has a history of domestic violence in a previous relationship. She has her own house but often chooses to stay with her elderly parents due to her excessive anxiety.

Barb: ‘Barb’, short for Barbara, is a woman in her early twenties, with a less entrenched eating problem due to her younger age. Barb stated that she was anorexic when she was fifteen years old. Barb now appears to be overweight, although she claims not to eat much at all, and never in front of other people, and seems mystified by her large size.
She struggles with depression, dissociation and self harming/suicidal thoughts, in addition to her eating issue. Barb has lived independently from her immediate family in the past, but is currently back living with her parents.

Neither of the women was employed or studying at the time of the group. Both clearly have significant mental health problems as well as eating issues. Both were having weekly individual counselling with Sandra, the co-facilitator of the group, concurrent with their group attendance. Prior to the group, the women were interviewed individually, as were the two other women who subsequently did not participate. The weekly group schedule was given out (see Appendix B) and the research was explained.

My decision to write this project as a dual case study was firstly, due to the fact that only two women attended the sessions, so it did not make sense to write it as a group case study. I chose to write about both women, as their images and verbal participation both complement and contrast with each other. In a sense this case study is a tribute to the depth of participation, and commitment to the process, which was often painful, that both Anne and Barb displayed. In this dual case study, I will briefly describe the ten sessions in turn, in terms of the plan, the activities undertaken, the art work created, and the written responses the women made to each session.
Week one: Setting group boundaries

Attendance
I discovered just before the session that only two women, Anne and Barb, would be attending, although a third woman, Fiona, was at this stage still planning to attend future sessions.

Goal
In this session, the goal was to introduce the women to each other, to ourselves, to art therapy, and to the research. We planned to discuss the purpose of the sessions and to share the goals of the participants, which had previously been discussed in individual interviews. We planned to create list of group guidelines, and a list of ‘hopes and fears’ for the group. We were aware that a great deal of time could be spent in this group setting the scene and alleviating some of the anxiety about what was to follow.

Discussion
The majority of the first session was devoted to housekeeping, boundary-setting, and discussing the proposed schedule of groups. We brainstormed the group guidelines, which were entitled “How this group will feel safe”, and which are a list of conditions to help create emotional safety (Chew, 1998). We also brainstormed the participants’ “Hopes and fears” for the group. The women’s hopes for the group meshed quite well with the original aims for the groups, which they had identified in their pre-group interviews. I added “fear of using art” to the list, as this had been mentioned in the individual interviews, but not in the group. These documents can be found in Appendices C and D.

The documents “How this group will feel safe” and “Hopes and Fears” were typed out and distributed to the participants in week two.
The group guidelines in the document “How this group will feel safe” were written inside the body outline drawing I had made prior to the group, drawn around my own body, which was subsequently displayed in the group each week.

The rationale for using a body outline which contained the guidelines, was to create a visual image, reminding the group of the eating issues focus, which would be displayed in the room each week. It therefore would provide continuity between each session, as a kind of transitional object (Winnicott, 1980) for the group. It also perhaps illustrated the group (symbolised by the body outline) literally incorporating the guidelines for safety. In the same way, the facilitators hoped that the women would internalise their experience of the group and integrate it into their own experience.

The reason I decided to use my own body outline, was as an example of role-modelling body image acceptance. My body at that time was not necessarily within socially acceptable norms, being slightly overweight, but I was nevertheless comfortable for its outline to be visually displayed. Perhaps on a personal level my decision also reflected my physical involvement in the groups and my embodiment of the group’s rules. In a sense it also depicted me containing the group, although in fact this was a shared task by both Sandra and me. I had a greater investment in the research aspect, but Sandra had the added task of containing the women in individual therapy outside the group. The issue of the art therapist’s body image is discussed further in chapter nine.

In addition to the above, I did not believe that either of the participants would be able to volunteer to use their own body outline at this early stage in the group. This was confirmed by the fact that, although an art activity based on body outline drawing was originally scheduled for week eight, in the event this was not attempted, as by that time we had changed the focus of the groups to reflect the participants’ experiences and
feedback. One of the reasons for the change in focus was their expressed concern about the body outline activity.

**Journals**

The women were each given a journal, and encouraged to use these to help them process the groups and record relevant events or insights, which occurred between the groups. The journals were not intended to be used in the research, but as a therapeutic tool. However, Barb chose to send me some extracts from her journal after the groups had ended, for use in this project (McLeod, 1994). These extracts can be seen in Appendix E. The journals were reviewed at the beginning of each session, and the women had the choice of reading out what they had written during the week. This proved to be a useful way for them to bring events from the week to group. The use of journals was not included in the research questionnaires. However, Anne identified “reading aloud from my journal” as the *most significant event* on several occasions. The participants were encouraged to bring music CD’s to the group, as a way of having a small sense of responsibility for, or ‘ownership’ of, the groups.

**Art Activities: Badges and round robin**

The first art exercise was to make a name badge for ourselves, using prepared conference badges, as a low-key way to introduce people to art-making. This activity proceeded quite well, although in a sense it was unsuccessful as the women were unable to wear their badges, as they were too wet with glue and glitter. The mood was light but with some anxiety, with a lot of banter from the participants towards Sandra, the co-facilitator and the social worker from the agency, who was well known to both participants as their individual counsellor.

We also did a “round robin” art activity, to further introduce the use of art to the participants. A round robin is an art based game similar to ‘consequences’, in which each participant draws or paints on a sheet of paper for a short period of time, before
passing their paper sequentially around the group, until each participant has worked on each sheet, and each sheet has returned to its original ‘owner’.

Since I was introducing art to the group in this activity, I offered a range of materials, including string for dipping in ink, and sponge applicators for paints. My aim was to provide different media to take some of the anxiety out of the process, which often centres on the belief of ‘not being able to draw’. It was an opportunity to ‘play’ with the art materials and find out how they worked. In fact on subsequent occasions the women mainly used collage and drawing rather than these messier materials.

The round robin was chosen as a group activity, to take the focus away from the individual women, and to allow them to try a relatively non-threatening exercise. It is a highly structured activity, which may also help to reduce anxiety, as there is no time to sit and think about what to do, and there are frequent instructions from the art therapist about when to pass the image onto the next person.

The images from the round robin (Figure 2) are fairly abstract at first glance, although some images emerge on closer inspection, such as snakes and ladders, stick figures, flowers, hearts, a female symbol, stars and a moon. There are also several mandala\(^{33}\)-like images (in two of the four images).

After the group, the women completed two weekly questions (see Appendix D) about the most significant artwork and the most significant event in the group. The ‘significant event’ question is derived from group therapy research (Bloch et al., 1985; Whitely et al., 1987). The artwork question is a variation of the second, and it aims to collect specific information about the images in the group. Both questions were utilised by Gilroy (1995).

\(^{33}\) ‘Mandala’ is a Hindi word derived from Sanskrit meaning circle or centre. Jung considered the mandala to be an archetypal symbol representing the self, the centre of personality striving for wholeness in the individuation process\(^{37}\) (Cox, 2003).
in her research project into experiential student art therapy groups. I placed the artwork question first, to indicate an emphasis on the imagery in the group.

In their written responses to the art work, both women identified strong feelings in relation to their artwork. Anne responded to the process, whilst Barb responded to the image. Both women responded to the exercise in which we identified hopes and fears for the group. This seemed to be the most emotionally charged issue for this group, particularly their fears. (Indeed, one woman had not attended due to her anxiety about the group). The fact of attending a group in which their eating issues were ‘made public’ and acknowledged, at least on a small scale and most significantly perhaps, to themselves, in itself seemed to be very challenging for both women.

<table>
<thead>
<tr>
<th>Weekly Responses</th>
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<tr>
<td><strong>Most Significant Image</strong></td>
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| *Anne:* “Doing the round robin artwork as it brought back some memories of my past”.  
*Barb:* “Round robin, because I felt that the completed image really portrayed the way I was feeling after this session. Confusion, spacey, a lot of things to think about, such as the feelings that the eating issue brings up.” |

| **Most Significant Event** |
| *Anne:* “Going through the hopes and fears as it made me realise more about myself”  
*Barb:* “Brainstorming hopes and fears for the group. It left a lot to think about.” |
Figure 2: Images from the “Round robin”
Week Two: Power

Attendance

Anne and Barb attended as in the previous week. We learned that the ‘third member’ Fiona, would possibly not be attending the sessions.

Goal

The goal of this session was to explore issues of identity, and attitudes to power. This latter theme was influenced by feminist therapy, in particular the work of Orbach (1982) and Rust (1987)’s adaptation of Orbach’s guided fantasy to an art therapy activity.

Icebreaker

We used symbols from the sand-play\textsuperscript{34} room as an icebreaker this week. This was another way to assist the women to think in symbols and metaphors to describe their feelings, and to stimulate their creativity. Anne chose a dog with raised ears to depict her “confusion about what was going on”, and Barb chose a mouse to express her wish to “run away and hide”. Barb was able to say that she was feeling like hiding in relation to me having asked her “lots of questions” about her art work last week. She was congratulated for raising this difficult issue, and there was some discussion about how she could have more control over this in future (for example, saying “no”). This issue tied in well with the theme for the week’s art work, of power and powerlessness. This theme also seems to have been expressed in their choice of symbols to represent themselves.

\textsuperscript{34} Sand play, first developed by Dora Kalff (1980) is a therapeutic method involving the use of sand in a large rectangular tray, which is moulded into various shapes and then discussed with a therapist. Symbols, which are small figures, toys, and other miniatures, can also be placed in the sand and may represent aspects of themselves or significant others. The activity described here used the symbols with out the sand (Pearson & Wilson, 2001).
Through processing the journals, Anne identified that she was confused because her eating issue was mixed up with her other issues. She also reported a dream in which she had to fill in a questionnaire with regard to her eligibility to be with an ex-partner. Taken at the level of the dream’s manifest content, this may have reflected some anxiety about the group process as a whole (and her eligibility to be part of the group), or about the research process in particular, which involved the use of questionnaires after every group.

Anne’s issue with the ex-partner, which involved domestic violence, had been stirred up in the previous week’s round robin activity. It had arisen again in the dream, and it surfaced again when Anne disclosed to the group, after completing her artwork, that she was a lesbian. This disclosure was the significant event she identified for herself that week (Thompson, 1994, p. 122). Anne was also feeling overloaded, as she was participating in another group as well, which was due to end in a couple of weeks. This group, also held at the women’s health centre, was an assertiveness training group, and had a more educational and skills focus than this therapeutic group. However, since the two groups overlapped by a couple of weeks, it is possible that some of the benefits Anne would gain from the sessions were attributable to the other group. Ideally in research only one group would be offered at a time.

Barb discussed a weekend family outing with her parents, and feeling uncomfortable at having a shared meal, but being able to overcome this by focusing on another person’s anxiety, and using humour. This could relate also to the group, and her realising one of the benefits of being in a group is being able to focus on other people’s issues as well as your own, although paradoxically in a group this small, there was not much possibility of hiding. This story also reflected control issues with her family, as she had not wanted to go away with them at the weekend, and suggests some transference arising in relation to my questions the previous week, in terms of her ability to take control of situations. Barb
was perhaps seeing me in a negative parental role and was feeling powerless to take action, just as she did at home.

**Art activity: Collage**

For the art activities for this second group, I selected the medium of collage, using magazine images pasted onto a sheet of paper to create a new image. Since it does not involve either drawing or painting, collage is often seen as a good introductory activity for clients who are not used to doing art (Makin, 2000). Both collage activities I chose for this session were sourced from the art therapy literature.

The first collage was to select “4-6 images that I like” (Landgarten, 1993). The aim of this activity is to introduce clients to collage in a fairly non-directive way, which is relatively non-threatening, and also allows for an element for self-disclosure through the choice of imagery. For this reason it is recommended by Landgarten (1993) for use as an assessment tool.

**Anne’s** collage (Figure 3) consists of five magazine images pasted onto a large sheet of paper. The largest and most centrally placed image, occupying the foreground of the collage, is a close up image of a glass of white wine, dewy with condensation, beside an opened wine bottle. Surrounding this image, are four other pictures. Three relate to leisure activities and are somewhat in the nature of a travel brochure. They depict, in clockwise direction, an aerial view of a paraglider, a picture of three Nescafe jars, a pastoral landscape depicting a golf course with mountains in the background, and another aerial view of a three-tiered swimming pool. A series of three container objects occurs twice in the images (the coffee jars and the swimming pools).

All the images are separate and spaced fairly evenly over the paper. All five images are cut into rectangular shapes, and are glued onto the paper in a rather haphazard manner, with at least three of them being tilted slightly ‘off square’ from the edge of the paper.
This does not quite resonate with the often repeated view that women with anorexia (a label that Anne may well attract in a medical setting) tend to be perfectionists, and are thus extremely careful in the execution of their artwork (Levens, 1987; Makin, 2000; Murphy, 1984).

Anne began her description of this collage by stating that it depicted things she “could not have”, such as a holiday (in case she felt too relaxed, and had a drink), or alcohol itself. She said she depicted coffee because she used it as a substitute for food, golf, which she would like to play again, and paragliding, which she would like to try. With the last two images, there was an acknowledgment that there were some ‘fun’ activities she could enjoy in the future, although she did not feel ready to try them yet.

Anne related the first collage both to her eating issue, and to her alcohol use, which she also identified as a problem. Anne was clearly a woman with multiple issues and may have been simply substituting one problem for another, although both her drinking and her eating had been problematic for several years. From my experience of working in the area of alcohol and drug treatment, I have come to understand drug and alcohol use as an attempt at self-medication in many cases, so that like eating problems it is often a sign of a deeper issue which has not yet been dealt with. This may fit with Anne’s presentation.
Figure 3: “Collage” by Anne

Figure 4: “Collage” by Barb
Barb’s first collage (Figure 4) included, on the left hand side, a picture of a car rearview mirror, with a man’s face reflected in it, which she said depicted herself “looking backwards instead of forwards”. We came to understand in subsequent weeks, that this looking backwards suggested her preoccupation with a past traumatic event. At the lower end of the mirror, was an image of a compass, which Barb said signified that she had “no direction in her life”. The fact that these two images, the mirror and the compass, are connected in the collage (the mirror appears to overlap the compass image slightly) suggests that the lack of direction Barb describes may relate to her preoccupation with the past. The fact that the face in the mirror is male, may be a reference to the male relative who, she later disclosed, had emotionally abused her. When she looks in the mirror, she sees a male face, who is clearly in the driving seat. This may also relate to the issue of control, which had been alluded to earlier in the discussion about journals. The image as a whole is suggestive of hypervigilance, as a reaction to trauma.

Barb’s collage also includes another cluster of images, on the right side of the paper. Two broken egg shells, nesting inside each other, have a cartoon-like face glued inside the inner shell. A small image of an orange cartoon tiger hides behind the egg shell image. Barb said she was the small tiger, hiding. She also identified herself as being inside the cracked egg shell, which she saw as a protection for herself. She said she did not know how she got inside it. She was peeping out, but could still retreat back inside. This again related to the issue of hiding. An egg shell does not actually offer much protection, especially once it is broken. It is supposed to be a place of nurturing and growth for the baby chick, but once it is broken, the chick has to survive in the outside world. The egg shell usually contains food for humans, too, but this one is empty. It also recalls the idiom, ‘walking on eggshells’, when a person is afraid of upsetting another, and has to ‘tread carefully’ around them, which was pertinent to her relationship with her abuser.
Another theme which emerged for Barb, and which emerged again in later sessions, was her identification with cartoon characters. Again this could be seen as a preoccupation with the past, in this case, with childhood, which felt safe. A further interesting element is the fact that she identifies with two characters, the face inside the egg, and the small tiger. Neither place, it seems, is a safe place to be.

Barb’s collage calls to mind the “Self/World” image described by Luzzatto (1994b). In Luzzatto’s schema, clients with eating disorders expressed their vulnerability and loss of identity by depicting themselves inside a prison (the egg shell), but with a danger outside which prevents them from leaving the prison (the man in the rear view mirror). Calling this the “mental double trap”, Luzzatto has noticed this type of image occurring spontaneously with her clients, when asked to depict themselves in relation to the world.

A striking feature with Barb’s image is the unusual compositional use of spatial positioning, scale and overlapping, which add to our understanding of her images and makes them work with each other as well as individually. For example, the egg shell is the largest image in the collage, although it is still relatively small on the paper. This contrasts with the tiny tiger, which is an inversion of ‘normal’ scale, as tigers are much bigger than eggs. Also, the juxtaposition works in another way, as here, the tiger is timid and hiding, and the egg shell is a place of safety, whereas normally a tiger is seen as powerful and strong, and an eggshell is fragile. Everyday reality, Barb seems to be expressing, is upside down; in my world, nothing is what is seems, or what it should be.

There are some interesting similarities between Barb’s artwork and the art work of “Carlos”, a client of Joy Schaverien (1995). Carlos, a young male diagnosed with anorexia, also drew several images with childlike qualities, depicting “cute” animals, with disproportionate scale (pp. 73-76). His work also included images of broken eggs and candles, which appear in some of Barb’s later work as well.
In terms of positioning, the two clusters of images mirror each other. They both slope upwards from left to right, and are diagonal to the horizontal and vertical edges of the paper. The effect of this is somewhat unsettling and ‘unbalanced’. The images are all clustered towards the bottom of the paper, and there is a lot of empty space above them. This seems to emphasise the disparities in scale even further, and it does this perhaps by suggesting the child’s eye view of the world, in which a lot of sky is seen above objects viewed by ‘looking up’ from an acute angle, rather than from an adult’s eye view which tends to see the world from a ‘looking forward’ (even this term is full of resonance with Barb’s tendency to ‘look back’) position.

In contrast to Anne’s collage, Barb is perhaps showing a more ‘sophisticated’ approach aesthetically. She has cut out her images rather than keeping them in rectangular frames, and has carefully placed them in particular relationships with each other, whereas Anne’s positioning seemed rather random and almost careless. Barb was much more comfortable with using art than Anne, as stated in their initial pre-questionnaire. Already, this seems to be apparent from the first individual images they produced.

In a sense one could argue that both images made compelling introductory statements about the women who produced them, despite the open nature of the directive they were given. Anne focused on what was denied to her, and what she desired. Similarly, Barb’s represented her lack of autonomy in her life, and her fear of ‘coming out of her shell’. Both were dominated by themes of fear, and lack of control. These themes were to be revisited in the following collage, which was completed in the same session.

*Powerful/powerless*

The second task, which followed quite naturally from the images just discussed, was to use collage to express the contrasting themes of “powerless” and “powerful” (see Rust, 1987). This task is derived from an activity described by Rust (1987), itself derived from Orbach (1982), for women with compulsive eating problems. In Rust’s (1987) activity,
the women visualise themselves at a party being fat, being thin, and being their ideal weight. The following week the participants make collages based on their visualisations (pp. 146-147). Rust found that issues of power were often underlying the women’s experiences of being fat and thin.

As we have seen in the literature, issues of power and control are very pertinent to eating issues (Crisp, 1980; Lawrence, 1979; Maclagan, 1998). The purpose of this collage was to start to look at these underlying issues of power and control, again using the relatively non-threatening medium of collage. The women were asked to make their collage on one sheet of paper folded down the middle to mark the division between the powerful and the powerless.

Significantly, perhaps, Anne (Figure 5) could only find one image for “powerful”, which was an image of a computer disc being held in a person’s hands. She said that using a computer and in particular, learning a new skill, made her feel powerful. This seemed to be Anne’s first positive statement in which she identified a strength. On the side designated “powerless”, Anne glued a cartoon showing a man who is looking underneath a carpet tile, which is one of a chequerboard of such tiles on an undulating sea of checks. The cartoon is titled “Check up” and the person checking the tiles is saying “Just checking…!” The cartoon is a play on the word “check”, but also contains an element of medical parody, in that it depicts what could be interpreted as a psychiatric condition and has the title “check up” which is what we go to the doctor for to make sure we are healthy. In my experience, jokes made at the expense of an individual’s mental health issues do not often go down well with mental health clients. However, in this case, Anne used the image to facilitate self-disclosure of her condition.

Anne said the man in the cartoon had obsessive compulsive disorder, (OCD), which is a psychiatric condition characterised by obsessional thoughts and compulsive behaviours.
Like the man in the cartoon, Anne stated that she had OCD and was being treated for it by a psychiatrist.

The other images she said she had, included a chicken running away from a person who’s head appeared to be cropped by the photo, and an advertisement for Hahn beer, of one a bottle in focus and one bottle out of focus, with the faint word rising between them, “impression”. The chicken represented fear, as in the use of the word “chicken” to denote a coward. The expression “running around like a headless chook” also comes to mind, especially as the person in the image literally has no head. The theme of alcohol is repeated from the previous image, possibly indicating how strongly this issue plays on her mind (surprisingly there are no images of food as one might have expected in this context).

The “central” image for Anne, on the powerless side, however, was that of a woman, standing on a dirt road with a crossroads behind her, with her hands on her hips and looking slightly down towards the ground and not directly at the camera. She in fact bore some resemblance to Anne physically. Anne’s comment about this image was to say “I am powerless over women”. On one level, she was referring to being a lesbian, and to feeling she had no power in a relationship, with reference to her previous experience of domestic violence. Perhaps also she is stating she feels powerless with regard to her own issues, since in a sense the image also represents her. As with the OCD cartoon, Anne uses the image to disclose her sexuality, an action which she states is the most significant event in the group for her. In her research project, Becky Thompson (1994) found that “coming out” as a lesbian was mentioned by several of the women as a therapeutic factor in their recovery from eating issues (p. 118). Paradoxically, Anne’s depiction of being powerless led to her making a powerful statement about herself in the session, and in doing so, taking some control in the group.
Figure 5: “Powerful and powerless” collage by Anne

Figure 6: “Powerful and powerless” collage by Barb
In Barb’s collage (Figure 6), as with Anne’s, the “powerful” images are on the left and the “powerless” on the right. The powerful images take up more space on the paper. Barb’s powerful images include: a picture of dirty male hands, making a frame through which we see bright green pastures, which Barb related to an image she had read in a poem; a colorfully dressed fashion model, walking down a catwalk with a man by her side, dressed all in black, who Barb said is “a pretty girl who can wear what she likes and doesn’t care what anyone thinks”; and a duck shaped house which was again about “not caring what people think”. Barb also depicted Tom Hanks in prison officer uniform from the film *The Green Mile*, as an image of male power. In addition, Barb had pasted down a second picture of a man and a woman, similar to the first one, but placed the man on the powerful side and the woman on the powerless side. This was seen as an attempt to bridge the gap between men and women, as well as a comment on gender imbalance as Barb saw it. Again it marks a more sophisticated interpretation of the task in going beyond it, to add a further dimension.

The “powerless” images for Barb included a computer game console: “when people play games, I feel powerless”; a candle, which “someone else can blow out”; a tall forest with a small person in it; and pills over which she feels powerless. The images themselves on the powerless side are generally smaller than on the powerful side. There is a similar focus on scale that was noted in her previous collage, as in the relative sizes of the trees and the person. Small size is indicative of powerlessness in this image, although the tiny pills, and the games console, are actually symbols of power for Barb; it’s just that she feels powerless in relation to them.

There are many dualisms in this image: the two male hands; the male and the female (twice); the two pill bottles and the two candles. This may relate to the two women in the group, her parents, or herself and her abuser (given the repetition of male and female) or indeed the two facilitators, with power being very relevant to all these possible interpretations. As noted earlier, the candle was also an image used by Schaverien’s
(1995) client Carlos. Barb’s image of the candle was to recur in a later group (Figure 15), as an image of her eating issue.

Barb kept a journal throughout the groups, as we had suggested. She sent me a copy of some of her entries after the completion of the groups. This was her comment about this activity:

_Barb’s Journal_

“I brought up a few scary things about my eating issue today that I’ve never admitted to anyone, including myself. Flicking through the magazine pages the bottles seemed to call out to me. They reminded me of medicine bottles and how I sometimes take enough tablets to make myself feel sick, and to not feel hungry. To get away with not eating for longer. I feel a slight release of pressure has been lifted from me, and while I know that just admitting the issue won’t make it vanish, at least I am more aware of it now. What I really need is to feel OK about me, and to not care about what anyone says or thinks. That’s the difficult part.”

The facilitators were both surprised by the high level of self-disclosure in the second group. Both women were talking a lot about their eating issue. This was despite the fact that the theme for the group was not specifically related to eating issues, although it reflected what we considered to be an underlying dynamic. Barb had described her weekend meal as having “all the posh people at one end of the table”. As Sandra and I were also at one end of the table, I commented on this. Barb laughed and said she did not see us as ‘posh’. By the end of the group, Barb was less scared than at the outset. Anne was still feeling overloaded. At the end of this session, Strength cards35 were spread out on the floor, and participants asked to select a card that represented one of their strengths. Barb chose “I can be clever” and Anne chose “I can listen”.

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35 Strength cards are published by St Luke’s Innovative Resources, Bendigo Victoria. Each card depicts a “strength”. They can be used to assist clients in identifying their own positive attributes.
Weekly Responses

Most Significant Image

Anne: “Barb’s picture of the man and the woman, as she said that he looked as though he was the most powerful”.

Barb: “The collage on powerful/powerless because I could really think about the things in life that make me feel powerless in particular. It has left a lot of thoughts swirling through my head”.

Most Significant Event

Anne: “It took a lot out of me to tell everyone that I was a lesbian”.

Barb: “The discussion at the beginning of the group regarding feelings and how we all work together to keep this a safe group”.
Week three: Self-image and safety

Attendance

Both women attended. Sandra, the co-facilitator, was absent for this session. She was in fact dealing with a crisis with the absent ‘third member’, Fiona, who needed to be admitted to hospital. I facilitated this group on my own.

Goal

The purpose of this session was to explore issues of identity and safety.

Icebreaker and journals

This session started with a Check-in activity using selected fabric scraps. Anne chose red, because she likes the colour. Barb chose blue stars, because she loves stars. She had decorated her niece’s bedroom with stars, to calm her down. I picked red stars, which combined both their choices.

There was some discussion of the women’s fears about this week’s art activity, which they had tried to predict based on their weekly schedule; perhaps this was scarier because Sandra was absent. Anne and Barb shared their journal entries. Anne said she had been thinking a lot about a past relationship, and how she attributed it ending, to her gaining weight on holiday. She was able to recognise her negative thought process, but thought it would be difficult to change it. This example indicates Anne’s level of anxiety about her body image, going on holiday and being ‘allowed’ to have her needs met. Possibly Sandra’s absence this week exacerbated her anxiety somewhat.

Barb shared some memories from when she had been anorexic as a teenager, aged 16, and had been regularly threatened with a syringe by her cousin’s partner (who she lived with at the time) if she did not eat. This was the emotional abuse she had alluded to in
the previous session. Her sister also tried to force her to eat, as did her grandmother. Her mother, who was a chef, also did not like to eat. Her father made up packed lunches, which her mother threw away. Barb’s whole family, evidently, seemed to be divided between those who did not eat, and those who tried to make them eat.

As discussed in an earlier chapter, Kearney-Cooke (1989, p. 14) argues that mothers and daughters often share a negative body-image. Indeed, we have seen that mothers of women with eating issues often have body image and eating issues themselves (Wooley et al., 1986, pp. 494-495). This has been noted in my clinical practice, and Barb’s family history supports that observation as well, yet in psychodynamic interpretations the focus is often on the mother-daughter relationship being enmeshed in an earlier developmental stage, as discussed in chapter two. The phenomenon noted here may prove a more plausible explanation for their close relationship, namely the mother’s identification with the daughter’s issues and a resulting ambivalence about treatment.

Art activity

The art therapy task was to make “a self-portrait as an animal in a safe place and an unsafe place”. The participants were also asked to pick three words to describe their animal (which were in fact descriptive of themselves, as it was a self-portrait), but second this directive was not given until the images were completed. This activity is a development of an art therapy activity called a “metaphorical portrait” (Liebmann, 2004, pp. 228-229). The additional aspect is the adjunct “in a safe and an unsafe place”. I added this environment element to enable further discussion about safety, and to help them identify the group as a relatively safe place.

Anne spoke at the outset of this session about her fear of not being able to draw. She said that her parents, who she spent a lot of time with, had referred to the group as “kindy” in a derogatory way last week. This comment referred to the fact that we were using art in the group, and was based on very limited understanding (but a common fear)
of art therapy and its role in the group. Anne was struggling not to be influenced by their criticism of the group, which tied in with her own feelings of inadequacy.

Anne drew a rudimentary picture of a pig with a head, a large red stomach, and an opening at the bottom (Figure 7). The image suggests the notion of food going straight through the body instead of being digested, which was intensified when Anne said this was her attempt to reproduce a poster of a pig she has on her toilet wall at home. She kept the poster to remind her not to eat, or to berate herself for “giving in” to food. I asked Anne to consider how helpful it was to have this image in her toilet, constantly giving her a negative message. She said in response that she would bring the poster in to group the following week. Both women related strongly to the image of the pig. Barb’s written comment at the end of the group was that Anne’s pig was the “most significant image” for her, because “its eyes seemed to glare at me as if it was calling out to me”.

On the bottom left of Anne’s drawing, to represent a safe place, is her house and garden, surrounded by a black line, which separates it from the rest of the drawing. This may reflect Anne’s sense of isolation, and of being different. Anne described her house as safe, although she later said she often slept at her parents’ house as she was too scared to sleep at home. This difficulty, which both women described, with experiencing a sense of safety, relates both to the fear of being alone, yet paradoxically also the fear of being with others. The presence of others means being seen, and thus being judged, as both women had experienced in their families of origin. This meant that for them, it did not feel completely safe anywhere.

Anne drew a picture of gym equipment beside the image of her house, describing the gym she went to as another safe place for her. However, this safe place also had a potential risk. Anne said she tended to go to the gym “too often” and spent up to 12 hours a week on the equipment. She also spoke about her severely restricted diet (cereal and yogurt) which basically involved breakfast as her one meal of the day. On the top
right hand side of the page, diagonally opposite her own house, Anne drew a house to represent the houses of friends, which she described as “unsafe”, because they contained food. There are 6 tables and chairs in the house and more outside, to represent “eating out”. Anne said she chose to avoid social situations which might involve food, and drank coffee as a substitute for eating. Anne’s three words to describe her pig were “sad, ugly and fat”.

Interestingly, both women reproduced pre-existing images, which they had a strong relationship to. This in itself may have been a safer option. Barb combined her images of safe and unsafe places in one picture (Figure 8). She drew a cartoon character, Eeyore (from Winnie the Pooh), surrounded by an image of Earth, with some countries and continents depicted, the moon and stars. Barb said that Eeyore was a character she could relate to, as he is usually portrayed as miserable. Barb’s Eeyore is smiling (even though he is miserable) and is holding a flower. There are two more flowers growing in the ground, one on either side of him.

Barb talked about usually feeling safe when she was alone, but still having to deal with her negative thoughts, usually about self-harming, which made her feel less safe. She said she saw the whole world as unsafe, but paradoxically felt safe at night under the stars. The image, combined with Barb’s words, suggests to me a child-like ability to be ‘in the moment’ and to forget external reality. The Eeyore figure seems to float in front of the globe, oblivious of it, lost in his own imagination. The globe appears as it would from space, with only Australia and New Zealand recognizable as countries.

Themes arising from Barb’s work include, again, the use of cartoons, the juxtaposition of scale noted in the previous week’s collages, and the child-like quality of her work. The image of stars was another theme for Barb, which would recur in a later picture. Again, there is resonance with the art work of Carlos (Schaverien, 1995): the animal image, the
disparity of scale and the imagery of the globe. The three words Barb used to describe her self-portrait were “sad, lonely and fat”.

Again, both women disclosed a great deal about themselves again through their artwork. At the end of the group, Barb said she was feeling unsafe and wanted to take a “heap of medication” and end up in hospital. Hospital was another place that was identified by both women as potentially both safe and unsafe, revealing the perceived risks in getting help from the medical profession. We discussed other ways of seeking admission to hospital, which did not involve overdosing. I asked Barb to think of strategies for keeping herself “together”, and she agreed to follow through on this. Ironically, at this time, Sandra was having our third group member admitted to hospital, and her absence may well have increased the feeling of a lack of safety in the group on this occasion.

In my notes for this session I wrote that “I was thrown, as usually there are some positives that come out of this activity…but there were none identified”. This comment referred to the fact that in doing this activity, people can usually identify some positive qualities that “their” animal has. It also raises the question of my need to find positives, and perhaps my counter transference that this group was not making the women feel better, in fact they were feeling worse than before, even though we had predicted this might occur. Sandra’s absence amplified this feeling for all three of us, as she was the pre-existing link between the members.

36 One of Carlos’ images is reminiscent of the double trap framework of Luzzatto (1994b). It depicts Carlos as a skeletal figure trapped inside a transparent bubble (the trap). Outside the bubble is a small globe, and coming from the outside are two hands holding needles which are being stuck into the sides of his head (the external threat)
Figure 7: “Self portrait as an animal” by Anne

Figure 8: “Self portrait as an animal” by Barb
However, although the group was painful, Anne was struck by the connection she felt with Barb in the session, which was a positive outcome for her. Barb left the group feeling bad, but she did manage to “hold it all together” and stay out of hospital, which was a positive outcome for her as well. The opportunity for both women to express difficult emotions, and to feel them contained, was a third positive outcome of the group that I overlooked at the time.

Weekly Responses

Most Significant Image
Anne: “My pig”.
Barb: “Anne’s drawing of a pig. Its eyes seemed to glare at me as if it was calling out to me”.

Most Significant Event
Anne: “How much connection as in feelings were the same (as each other’s) this week”.
Barb: “The feeling I spoke about with the whole world seeming so unsafe. Everyone around me. Everything around me”.

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Week four: Inner critic

Attendance

Both Anne and Barb attended the group. Sandra was back as co-facilitator.

Goal

The purpose of this session was to focus on the “inner critic”. The inner critic is a term derived from Cognitive Behavioural Therapy (CBT), and is used to describe the negative self-talk that many individuals with low self-esteem experience. The “harpy”, which is the theme of the art work created, is a term derived from Greek mythology, is a personification of these negative thoughts that women experience in relation to their body image, and attitudes around eating and food. Since we were introducing a new concept, that of the inner critic, the group had an educational component, as well as an art activity which related to the topic.

Journals

The group began with a discussion about the previous week. Barb said she believed her eating issue was getting worse. She described her parents “forcing” her to eat, and consequently deciding to eat less in other situations. It is not clear what Barb meant by “forcing” her to eat. We discussed how we had predicted that focusing on their eating issues could make them more troubling for a while, and this was a normal process.

Barb spoke about her relationship with her mother, and related a dream in which her mother “closed the blinds” which she understood to be about her mother shutting her out and being unavailable. Barb said “I would like to get support from her but I don’t. I know I have to help myself, do it on my own. It’s hard”.

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Barb was wearing a sweatshirt with Winnie the Pooh characters on it, including Pooh, Tigger and Piglet. Barb’s choice of clothing is reminiscent of her tiger cartoon in the second session and her Eeyore cartoon in the third week. She again seems to be highlighting her identification with these child-like cartoon characters, which is all the more poignant given the perceived rejection by her mother that she had just spoken about. Perhaps this is an unconscious plea to me and Sandra to mother her in the group setting. Schaverien (1995) makes a similar point in relation to her client, Carlos’ childlike images:

Very often the child image relates to the lost object; the desire is for the object which originally evoked the desire and is experienced as its cause – perhaps the mother…it is an abandoned element in the psyche which is unconsciously carried by the child image. (p. 158)

Anne said she had remembered “sneaking” food as a child, as she did not feel entitled to treats such as lollies, due to being part of a large impoverished family. However Anne admitted to still feeling guilty about eating as an adult, particularly when she starved herself then binged after drinking alcohol, when her guard was down. Anne also brought in the pig poster (mentioned in the previous session) to group (Figure 9). She said she had not decided whether to keep it in her toilet or not, but her sharing of it with us felt like a big step in terms of another self-disclosure, this time of an image. Schaverien (1995) writes about the image as gift, arguing that the giving of the gift is an aspect of the transference (p. 55). In this case, the pig poster was given to the therapist to keep Anne safe from its negative message.

Both women were bringing a wealth of material including dreams and childhood memories into the sessions, which contributed to a sense of richness, in spite of the low numbers. The strategy used on this occasion, to discuss the concept of the inner critic and then attempt to illustrate it, is very different in its approach from most art therapy interventions, although a section on “Psycho educational approaches” is included in one edited art therapy book (Rubin, 2001). The general rule is that the art making comes before the discussion, not afterwards. Didactic approaches are not usual. The method is
more akin to cognitive behaviour therapy, with art therapy used as an adjunct or illumination of the theme.

The women were given handouts taken from *Mary Jane: Living Through Anorexia and Bulimia Nervosa* by Sancia Robinson (1996), which illustrates the concept of the inner critic with an example from Robinson’s own experience of eating issues. Robinson calls her inner critic “Fanny, my alter ego”. She also calls her “false self”, “ego” and “trouble”. This topic is also illustrated by cartoons by Judy Horacek, which were shown to the women as well.

Before we progressed to the art activity, we watched a brief video cartoon entitled *Gorgeous* by Kaz Cooke (1994a). This animation illustrates the concept of the inner critic, which is personified as a “weird fairy”, Deirdre, who hovers on the shoulder of Hermione, the protagonist of the video. Deirdre berates Hermione with an ongoing stream of critical comments based on the events in her day, with a particular focus on body image: this includes eating breakfast; going to the gym; buying clothes; and in the consulting room of a plastic surgeon. At the end of the story, Hermione visits the art gallery (where she is applying for a job), and she converses with the images of women in the artwork, about women’s changing body-image in art. The video explores the issue of the inner critic with humour, but gives a brilliant and graphic illustration of what many women experience daily, but are barely aware of.
Figure 9: Anne’s “Pig poster”
After viewing the video, and discussing the concept of the inner critic, we asked the women to relate any negative messages they had received and internalised about food or body image, and to identify where these messages had come from. **Anne** was able to identify a strong message: “Don’t eat or you’ll get fat”. This message came from her parents. We also looked at the consequences of these thoughts: for Anne these were to drink coffee, avoid eating, and go to the gym. **Barb** could also identify with these negative thoughts. Initially she did not think she could add any of her own. Eventually, Barb identified: “If you can’t do something perfectly, you’re a failure”, which she said came from herself. For Barb, the consequences were to drink Coke and to self-harm. She also said she could visit her sister and “act like an idiot”. The women were starting to make links between their negative thoughts and their non-eating, and sometimes risky, behaviours.

**Art Activity: “Harpy”**

The use of the term “harpy” is derived from an activity developed at Isis, Centre for Women’s Action on Eating Issues, which formed the basis of the art activity this week. The activity we suggested was to create an image of the inner critic or harpy using art materials. We discussed the term “harpies”, which refers to winged creatures from ancient Greco-Roman mythology, which “were represented as birds with the faces of women, horribly foul and loathsome” (Encyclopedia Britannica, 2001). Harpies are generally seen as female and obnoxious creatures, which can be sent as punishment from the Gods for some wrongdoing. In contemporary popular culture, a harpy is a woman who is very bitter and critical of others.

We also showed the women different representations of harpies and other mythical creatures. There was a Jungian element to this activity (Jung, 1954b), as it tapped into images of fantastic creatures from fairy tales and other archetypal sources. We then asked the women to make an image of their own inner critic, or harpy.
Figure 10: “Harpy” by Anne

Figure 11: “Harpy” by Barb
Figure 12: “Megaphone” by Sandra

Figure 13: “Harpy” by Claire
Anne, who found this whole session particularly challenging, became almost totally immobilised by the art activity. She revealed later that she almost left the group rather than deal with her feelings of inadequacy around art. However, as painful as this was, Anne did work through this and she produced a drawing, which depicted her harpy as a small creature drawn in felt pen on an A4 sheet of bright orange card (Figure 10). The creature had a forked tail instead of legs and had a smile on its face. Under the image Anne wrote the letters “OK”, which she said was a message to herself that she was OK. She said this enabled her to stay in the room and complete the group. There were other examples in later groups of Anne finding the use of words and writing therapeutic.

This session involved an intellectual challenge to the women as well as touching on difficult emotions, and Anne was literally wrestling with her inner critic about her entitlement to participate. The experience was initially too real for her to feel comfortable but the art, in this case, did eventually contain her anxiety. Anne seemed to be able to use the art activity to distance herself from her internal experience, which was too intense. As with the previous group the women were experiencing powerful emotions in the sessions, and due to the low numbers of participants were unable to ‘hide’ from these feelings.

Barb created a drawing of a harpy based on her hand outline, on A4 yellow card (Figure 11). She described it as a creature which sits on her shoulder and scratches. Barb’s harpy has a cartoon-like quality, but is very different from her previous cartoon imagery. This cartoon face is like something out of a horror movie, or a Grimm’s fairy tale, with bloodshot eyes, a blood-red forked tongue, and a long pointed nose. Its hair is wild and curly and it has sharp nails on its fingers, which do the scratching Barb described. Some of the physical characteristics, especially the curly hair and the pointed nose, could have been unconscious representations of myself, as an aspect of negative transference! Given
Barb’s strong positive attachment to Sandra, and some of the fears she expressed about myself after the first session, this seems a reasonable conjecture.

Facilitators’ artwork

Sandra created a megaphone from cardboard (Figure 12), to reflect the “amplification” of the negative message by the individual. This is an example of art-making by a facilitator as a teaching tool, which serves to illustrate a point that could not be made so well verbally. It also demonstrates empathy with the women, as it shows an understanding of their experience which again could not be made in words.

In a similar vein, I made a model of a harpy as well (Figure 13), like a winged cat with sharp claws, and hands that can grab and scratch.

### Weekly Responses

#### Most Significant Image

*Anne:* “The loud speaker which was made as its like we all have one at times”.

*Barb:* “My harpy, because its always on my shoulder, scratching”.

#### Most Significant Event

*Anne:* “Sharing my most inner feelings with the other members”.

*Barb:* “Discussing the journals. Even though I hadn’t written much it was a relief to talk about what I had written”.
Week five: Image of the eating issue

Attendance
Both women attended.

Goal
The goal of this session was for the women to explore their eating issue by creating an image of it. This type of directive is fairly unusual in art therapy. It asks for a direct representation of the issue that has brought them to therapy, and as such is confronting. It is perhaps less so if we think again of the eating issue as being the symptom of a deeper conflict, as describing the eating issue can be about describing behaviours rather than thoughts and feelings.

Anne was challenged by Sandra to sit in a different chair. Perhaps only Sandra could have done this, with her prior knowledge of Anne, and it was a planned challenge based on her knowledge of Anne at that time. Anne refused to move, saying it was her OCD (obsessive compulsive disorder) which made changing impossible. Both women said they were worried about doing the art activity. They were pleased I had brought in collage pictures, thinking this would make the task easier, at least technically.

Journals

Barb had written a poem, entitled Camouflage, (see Appendix F) as a response to the previous week’s activity, and she read it out loud. She read out another poem about masks. She was demonstrating, through her poetry-writing, another strategy for dealing with her negative thoughts and feelings, which turned them in to something which was more benign, and which communicated her feelings to others.
A similar change occurred with Anne. Anne had been preoccupied with her journal entry from the previous week, about sneaking food. She noticed that she felt bad about sneaking food until she wrote about it in her journal. Again writing was proving therapeutic for Anne. She had stopped trying to sneak food, and was reporting what she ate to her parents. Sandra and I were alarmed about the potential of this to create a more powerful dynamic with her controlling parents, and suggested to Anne that she only try to avoid sneaking food on some days. This served as a paradoxical intervention, but also because we did not want to give Anne greater opportunities to further limit her food intake.

The Australian documentary about a young woman with anorexia, Bronte’s Story, (26th March 2000, Channel Nine) had been shown on television in the week since we last met. This sparked some discussion, with both women identifying with Bronte. Barb asked whether anorexia or bulimia was more serious.

Barb stated she was “getting worse” and said she was hardly eating at all. This was interesting in the light of the previous conversation, as Barb was not anorexic, but clearly seemed to need to demonstrate the seriousness of her eating issues. Possibly an element of competition was developing between the women at this stage. This would be likely to be more acute given the small membership. I wrote in my journal “I had a sense with Barb that she is holding back a lot, keeping it all inside her, compared to Anne, who lets it all out (and feels better)”.

Art Activity – Representation of eating issue

The task this week was to create an image of the eating issue as they experienced it. Anne chose to use magazine collage, and as a result was not immobilised by her fear of art, as she was the week before. Her image was of the profile of a head, with divided sections as in phrenology, surrounded by food: nuts; Carnation milk, a meal set out on a table, and an entire fridge with open doors (Figure 14). The collage also included other
forbidden items, such as holidays, a theme which also arose in week two. Anne had pasted the word “No” firmly above the head, creating a barrier between the head and the other images. The “No” was somehow the opposite of the “Ok” of the previous week.

Anne had created a poignant image of denial and lack of entitlement. We discussed whether it was Anne or the harpy that did not want her to eat. The harpy activity had given us a new vocabulary for discussing these issues about negative thoughts with the women. We were further able to examine Anne’s rigid, obsessional thinking when we explored her phobia about going on holidays. She stated that she had once binged on holiday, as she had told us, so therefore holidays were not safe. This was a good example of her black and white thinking, and catastrophising. Underlying this was her fear of losing control.

**Barb** worked in clay, which was one of a variety of media available. She sculpted a candle with wax dripping down the stem (Figure 15). Barb felt quite disturbed by it. She talked about “melting away” and someone “blowing the light out”, both of which could be interpreted as metaphors for suicide or death. She had included a candle in her collage of three weeks ago, as an image that represented feeling powerless.

The candle with wax dripping down could also have a phallic, sexual meaning, although this was not consciously identified by Barb. This was suggested also by the fact that Barb said she found the sensation of using the clay “disgusting”, and also by her comment after the session that the most significant event that week was “just playing with the clay. Squishing and moulding it with my hands”. I had noticed the image of dirty (male) hands in her powerful collage, which had initially alerted me to the possibility of sexual abuse. Barb had also written about “dirty hands” in one of her poems.
Barb was withdrawn after making the candle, and said she felt like crying. She said she partly wanted to smash the candle and partly didn’t. Others in the room gave her permission, but she did not, neither did she cry. It seemed too hard to let go. I admit I was relieved – I did not want the candle destroyed (the researcher role taking priority over the therapist here), not just for the sake of the research. I also thought the image of the candle was a self-image in a way (rather than being directly about the Barb’s eating issues) and she had already alluded to the candle being “blown out”.

Barb was clearly making a lot of connections, but was fearful of self-disclosure in this environment. What the dilemma of whether to smash the candle signified for me was Barb’s ability to self-sabotage, particularly by her non-disclosure and difficulty in taking positive steps to change her situation. The candle was as poignant as Anne’s “No” collage, in its suggestion of a spirit that is easily extinguished.

Both images flowed on from the discussion and exploration of the harpy the week before. They both in particular managed to suggest ambivalence, which I believe the harpy activity had enabled, in expressing both their desire to be free of their eating issues, and their difficulty in letting go of these behaviours. In other words, instead of feeling overwhelmed they could perhaps start to identify an internal dialogue which gave them back a sense of control.
Figure 14: “No” by Anne

Figure 15: “Candle” by Barb
Both facilitators also used clay. Sandra created a box (somewhat coffin-shaped, which again echoed with resonance with the seriousness of the problem) of “Maltesers” (Figure 16). The box was the eating issue and the Maltesers represented what lies beneath (or, literally, inside) the eating issue. I commented that the box reminded me of a coffin – things buried in the ground, digging up old things, and literally death which had also been a theme in the group.

I made a figure of a female body emerging from a shell, with overtones of both the Venus de Milo (without arms) and Botticelli’s Birth of Venus (one of my favourite paintings). The references to famous art works reflected my own interest in the representation of women in art, but may have been difficult for the participants to understand. Perhaps I was being “too safe” in choosing a rather academic theme, rather than something about my own experience, although I did make the statement that on some days I feel good about my body and on some days I feel bad.

Barb said she would have to miss the next session, as her niece was having surgery for reflux (another food issue in the family) and she was her niece’s support person. This brought up fears for Anne of being “the only one” next week, which was scary for her.
Figure 16: “Maltesers” by Sandra

Figure 17: “Wants and Needs” by Anne
We started to discuss the ending of the sessions, as we were now half way through, in particular the need to agree on an appropriate ending “ritual”. In their case study of a West African refugee, Zwart and Nieuwenhuis (1998) describe their use of ritual in therapy, stating that:

Always and everywhere people use rituals and ceremonies to make the transition to a new stage of life. Rituals mark the vital moments, the critical stages in people’s lives. (p. 73)

In our case, we wanted to have a celebratory ritual at the end of our sessions, to recognise the work already done and to provide a stepping stone to Anne and Barb for their lives after the group. Despite the short time frame of the group, it was already clear, from the depth of sharing, and the richness of the artwork, that this was an experience that would be likely to be significant for both women.

The mid-term questionnaires were also completed after this group.

Homework was also given, but the participants were given a choice about whether to complete it. This involved a worksheet with questions such as “list three things you would like to change about your body”. Following on from that, was another worksheet which explored the difference it would make if those changes occurred. The worksheets introduced some feminist thinking about body image and eating. Basically their purpose was to look in more detail at the participants’ irrational beliefs about weight and physical appearance. The third worksheet explored positives. They were also given affirmations by Kaz Cooke (1994b) and a list of “Goals to Keep in Mind”, such as “See your body as a trusted and treasured home for yourself to enjoy and use fully, rather than as an aesthetic object” and “Reject the destructive social prescription to be as thin as possible in your every thought, work and action”.

I came away from this group feeling concerned about Barb not talking. She was still not going well and seemed “stuck”. Anne on the other hand gave herself a “gold star” for her participation, which seemed to be buying into her parent’s mockery, but also perhaps
laughing at herself. She was genuinely pleased by her ability to participate more easily this week. The two women seemed to become polarised at this point, with Anne going well and Barb going less well.

**Weekly Responses**

**Most Significant Image**
*Anne:* “The picture I had of inside a person’s head, how it can give out so many negative messages”.
*Barb:* “My candle – I just want to melt away. To stop having to think anymore”.

**Most Significant Event**
*Anne:* “Be(ing) so honest about how to get the messages as mentioned above and also sharing my journal”.
*Barb:* “Just ‘playing’ with the clay. Squishing and moulding it in my hands”.

Week Six: Wants and needs

Attendance

As expected, Barb was absent this week. During the week, Anne had told Sandra that she was sexually attracted to her. The facilitators were aware of this issue but left it up to Anne to decide whether to bring it to group. The issue was not discussed in the session.

Goal

The goal of this session was to enable Anne to identify her wants and needs, using a phototherapy and collage activity. We decided as facilitators to take turns to talk, so as to reduce the sense of ‘two-on-one’ in the session. Also, to challenge Anne’s rigidity, I sat in ‘her’ chair. The reason I sat in the chair rather than Sandra, was due to the erotic transference developing from Anne towards Sandra.

The erotic transference between Anne and Sandra provided an additional complicating element to the relationships unfolding between the four of us. It is interesting that it arose at the same time as us exploring “wants and needs” in the art activity. Sandra was very clear about her own professional boundaries and these were maintained throughout her work with Anne, so that no acting out would occur. In terms of Anne’s issues Sandra perhaps represents something else she is not allowed to have, and indeed this may have been part of the attraction. It also perhaps represents a denial of the difference between herself and Sandra, with herself being the client and Sandra being the therapist.

Joy Schaverien (1995) writes about the experience of erotic transference in *Desire and the female therapist: engendered gazes in psychotherapy and art therapy*. She is mainly concerned with heterosexual transference between the female therapist and the male
client. However, Schaverien suggests that erotic transference also occurs in same sex therapeutic relationships, whether the individuals concerned are homosexual or heterosexual (p. 10). She says that often, for female therapists, “it is accepted as ‘normal’ because it is understood to be maternal” (p. 9). She suggests this could amount to denial of the erotic transference. Schaverien acknowledges that “it remains a question, for further exploration, whether there is a difference if therapist, patient or both are homosexual” (p. 42). My hypothesis would be that there is no difference, although in same sex situations with a heterosexual therapist, the therapist may experience a stronger counter-transference reaction, particularly if they have unexamined homophobia.

**Journals and discussion**

Anne was flustered when she arrived. She had just driven from another rural centre an hour away, where she had seen her psychiatrist. She had an issue with me sitting in ‘her’ seat, but did not protest much. She expressed her fear of being the only participant, with Barb absent.

Journal reading was now being used every week as a check-in. Anne brought up her anxiety about last week, namely her feeling that she had done the art activity ‘wrong’ because she had been the only one not to use clay. She was given reassurance that this was ok. She had completed the worksheets at 4am the night after the group. She had also had nightmares that night related to a previous violent relationship. I was unsure of the connection, but we talked about “feeling sneaky” when dominated by someone (for example, not being allowed to talk to other women). This was related to Anne’s issue about “sneaking food” when she was younger, and not feeling entitled.
Art activity: Want and needs

The art therapy task was to make a collage of wants and needs using Photolanguage images, magazine pictures and other collage materials. The collage was to include a photo of the participant, taken with a Polaroid camera in the group, images to represent wants and needs, and a frame of some kind. The aim was for this to be inclusive of self-image but to be a non-threatening, nurturing activity. Anne was comfortable with this task.

In the top left hand corner of her collage, it is apparent that Anne has covered most of her photo, except her head, with an image of tablets/pills (Figure 17). She described pills as her “security blanket”. Later, she talked about bringing a soft toy, a dog, to the next session: her transitional object. Joined to the image of herself, is a large old Queensland style house with a verandah. There is a photograph of an orderly garden with topiary trees on either side of a pathway, on the right hand side of the collage. Anne said she had been doing landscaping in her backyard; this was an activity Anne enjoyed which she was able to do. In the bottom left hand corner is an image of a computer, which represented a positive skill Anne was learning, as she mentioned in her “powerful/powerless” collage.

The central image of the collage is one of a woman sitting alone in a bleak landscape. Anne seemed to identify strongly with this picture, and she mentioned it in her weekly summary. To the left of this image, is a small picture of three smiling women out together at a social event, juxtaposed with the solitary figure and emphasising her isolation. She is in black and white, and they are in colour. The three women could be a reflection of the three women in the session that week, Sandra, myself and Anne.

Photolanguage is a resource published by the Catholic Education Centre, Sydney. It consists of a set of black and white photographs for use in group work. They can be used as prompts for discussion or can be photocopied and incorporated into collage, as we did in this instance.
Below and to the right, is a group of women racing at an athletics event. Anne said she was missing out on participation in sport due to an old injury: it was something else she felt deprived of. The image of women racing suggests an element of competition, perhaps for Sandra’s affection, in which case the three women together could represent Anne, Barb and Sandra. Alternatively, since Anne identified at some level with the solitary figure, the three women could represent the rest of the group (Barb, Sandra and myself) having fun whilst she is excluded. The possible interpretations are endless, and I include two different ones precisely to make the point, that this is speculative and should be understood as such.

In between this image and the woman alone in a landscape, forming a bridge between the two larger pictures, is a small square image of a face in the shape of a heart, and the words “Love me please”. This may have been a message to Sandra, in the light of Anne’s earlier revelation. Anne wrote the word “body” in gold glitter on the right hand side of the paper, thus showing its separation from her head. She said it was “safer” to represent her body using a word rather than an image. I have mentioned elsewhere that Anne often included words in her artwork. In this case it enabled her to include her body in the collage and not include it, at the same time. This seems to me to be a strong statement demonstrating the double bind of Anne’s anorexia, something like its not acceptable to have a body, even though one cannot live without one.

The frame down either edge of the paper is made of cut out pictures of curved iron chair legs. They are rigid and concave, but the structure is open. In between, Anne has pasted musical notes, which she identified as a positive, for relaxation. The top and bottom frame is made of a glittery wavy line in pink. These elements seem to show Anne becoming more creative in her approach to the art therapy task. New elements include the use of glitter, the joining of related images, use of unusual images such as the iron chair legs, and the thoughtful juxtapositioning of various elements. It is almost as if Barb’s absence has given her permission to be come more creative, like Barb.
Anne’s collage identified themes of social isolation, her need for routines, her OCD, her wish to be loved and her desire to live in her own home. In this collage, Anne seemed to be managing to contain opposites whilst at the same time identifying splits: open/closed; solitary/sociable; needing others/need to be alone; head/body; rigid/flexible (she was able to tolerate being in a different chair), and so on. Splitting was identified in chapter two as being a feature of anorexia. Anne seems to be demonstrating a way of starting to integrate these opposing parts of her personality, at least by identifying them.

Sandra and myself also made collages and shared them with Anne. Anne left the group a lot calmer than she had arrived. She said the activity was alright as we all did the same, so didn’t feel she got it wrong. Anne’s difficulty in accepting difference had also been revealed in her disclosure to Sandra. For example, she was denying the counsellor/client boundary, as well as a denial of Sandra being heterosexual, which she almost certainly would have known.

This session had a nurturing and relaxing quality to it. However overall, we were feeling a high level of anxiety about the women’s experiences: Barb’s apparent relapse and to a lesser degree, Anne’s fear of using art.

### Weekly Responses

**Most Significant Image**
*Anne*: “The picture of the girl sitting on her own”.

**Most Significant Event**
*Anne*: “That I got through the afternoon without sitting on my chair. Also reading my journal”.

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Change of direction

After this session, Sandra and I had a supervision session with an external supervisor (who was a feminist psychotherapist experienced in working with eating issues). We discussed with her whether to keep to our original plan, or to change our focus for the next four sessions. The issues discussed included: the small number of participating women; the difficulty Barb was having to participate at times; our fears of the women ‘getting worse’; their fear of using art; and the short time frame of the sessions. We decided we were trying to push them too fast, thereby highlighting one of the dangers of a directive group (McNeilly, 1984, p. 7). This supervision session resulted in Sandra and myself deciding upon a redirection in the group, towards a more nurturing approach, and away from some of the more challenging activities we had planned for the forthcoming sessions. This felt like a huge relief for both of us.

The other point about the plan, was the facilitators’ need to have the sessions clearly outlined before we started, perhaps indicating control issues of our own. This was usual practice at the centre, but as stated earlier, most of the groups were psycho-educational rather than therapeutic. It may also have been a feature of the research, in having particular strategies I wanted to ‘test out’ in this group. In the event, we probably should have resisted the urge to have a plan so concretely outlined at the outset. The use of directives can be used spontaneously as well as in a controlled manner.
Week seven: Refocusing

Attendance
Both women attended.

Goal
To renegotiate the direction of the sessions with the women, and to introduce a new plan for remainder of sessions.

Discussion
We spent most of the session discussing the new direction we were taking. More time was to be spent on ‘nurturing’ activities and less time on more difficult, challenging issues such as families and body image. Ironically, nurture was a challenging issue especially for Barb, who often struggled with issues of feeling unentitled. Both women had experienced nurturing by a rigid, controlling, family structure. In this context, our modelling of flexibility and change was very significant. Not surprisingly, the change itself proved to be the most significant event for Anne.

Towards the end of this session, we brainstormed ideas about self-care. Barb could only think of negatives, for example, “don’t do this, don’t do that”. She picked up on this insight and used it. We wrote up themes such as self-care, safety, nurture. We again discussed how to celebrate the ending of the groups.

Worksheets
We discussed the worksheets given as homework in week five. Barb had been unable to complete hers. She said it was “too hard to think about”. Anne went through hers. What
transpired was that her issues were to do with her attitudes, not her physical body. She found this very confronting.

Barb talked about her niece’s surgery, and how she had been thinking about the group when it was on and she was in hospital. Her niece had got an infection in hospital and is on a restricted diet. This brought up more issues, for example about having to withhold food from her niece, and not eating herself, and this being noticed.

Anne was starting to make links between her eating issue and her experience of domestic violence.

The women were given another worksheet to fill in, which asked them to complete the sentence: “if I was a person who deserved love, respect, success etc, I would…” Barb completed this and reported back in the following group. Anne declared she was “unable to imagine” being such a person.

No art work was done this week, as we spent the whole time discussing the change in plan, and the worksheets.

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<tr>
<th>Weekly Responses</th>
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<tr>
<td><strong>Most significant image</strong></td>
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<tr>
<td>(No art work done this week)</td>
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| **Most significant event** |
| *Anne*: “Changing the original plan”.* |
| *Barb*: “Thinking about ways we could nurture ourselves” |

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Week eight: Self care 1

Attendance

All attended the session. This session had been rescheduled, as neither Anne nor Barb was able to attend at the original time, for medical reasons. Anne was having surgery on her right hand, for carpal tunnel syndrome. Barb was still involved with caring for her niece, as her sister was about to have a baby. This meant that there was a three week gap between the previous session and this one. This included the Easter break. We would then return to a weekly attendance footing. Having a three week break was not ideal but was feasible at this stage in the process. Both Anne and Barb were showing a high level of commitment to the group. The only absences were planned and for genuine reasons. So again, Sandra and I demonstrated flexibility in accommodating their needs. In a larger group, this would probably not have happened, but without these two, we had no clients.

Check-in activity: Soft toy

Both women had agreed to bring a favourite soft toy to the session. The purpose of this was to explore their meanings as transitional objects and symbols of nurture. Anne forgot to bring her toy, but was able to talk about it as if she’d brought it. Barb brought in a stuffed Disney toy, Eeyore, saying “he’s beautiful and very sad”. Barb also had a picture of Eeyore on her folder (for handouts etc.) and she had depicted him in her “animal self-portrait” image, as described in week three. Anne described a toy monkey she has at home. She said she has a few toy monkeys, and that she likes them as they are “like people, but safer”.

Sandra and I brought in soft toys as well. This activity was likely to be seen as childish by the women (perhaps this was why Anne forgot?), so in keeping with our goals we participated to help normalise the experience.
Barb had written about her experience of writing the worksheets. She became very angry (with herself) for being stuck at the moment. She was starting to make links with her family’s expectations and her own. Feeling angry was very different for Barb. She was re-energised and seemed a lot more engaged in the session. She had been thinking a lot about the group over the Easter break. She was still looking after her niece, as her sister was just about to give birth; in fact her waters had broken just before today’s group. Possibly Barb was enjoying taking on a nurturing role with her young niece. Anne and Sandra both gave feedback to Barb on not following others’ expectations in order to get love, saying it doesn’t work.

Anne had just had surgery on her right hand. Her stitches were not healing, as Anne was not resting. She was feeling low due to being incapacitated and unable to go to the gym. She said: “It looks as if I’ve slashed my wrists”. She had not written in her journal but denied this was due to her physical incapacity: she said it was due to having “no complaints” or unanswered issues from the previous session. She was saying her family gives her unconditional love, and that she didn’t think her situation was the same as Barb’s. There are some indications here that Anne is making progress. She was able to offer support to Barb, she has no complaints, and she can acknowledge differences between herself and Barb.

We had another discussion about the final group. Both women were being encouraged to agree to meet at a different venue, Colleges Crossing, a local picnic spot, for the last session. The reason for this suggestion was to differentiate the final group from the one’s that had gone before, seeing it as a celebration, and to symbolically bring the women out into the real world in an ending ritual (Speiser, 1998). The notion of meeting in a different place for the final group is not one that is usually considered in ‘traditional’ psychoanalytic art therapy groups, in which consistency of time and place is seen as one of the key features that builds safety and trust (Case et al., 1992, p. 56). This concrete
representation of safety seems to have been very real for our participants: Anne was very resistant to going elsewhere, and Barb was unsure. They had great difficulty making a decision, perhaps still struggling with being able to state their needs. I wondered if they were used to being asked for an opinion. Sandra would be unable to attend the following (second to last session), so the issue needed to be resolved. We agreed to draw up a list of options to discuss next week.

Art activity: Egg and capsule

This activity is one I developed when working in an alcohol and drug rehabilitation centre, with the goal of assisting women to think about self-care in a very concrete way. It is an elaboration of the self-box collage, mentioned by various art therapists (Fleming, 1989; Rabin, 2003), who emphasise the importance of working on self-image with this population. In the self-box activity, the task is to create a collaged box or other container, using images to represent the client’s “inner and outer selves” (Liebmann, 2004, pp. 223-224). The extension of this activity, which I developed[^38], was to place an egg (with the contents blown out) inside the box to represent a part of the self that needs to be nurtured, and for the box to be created as a safe place for the egg.

I had brought in two duck eggs (from my ducks at home). The task was to use recycled materials (such as boxes, or other containers) to create and decorate a safe capsule for the duck egg, and then to carry it around for 24 hours. Both women were very dubious about this activity and unsure if we were serious. They wanted us to do it too, which we did. There was a lot of laughter in this session.

Due to her right hand being in bandages, Anne had needed help making her capsule, but was unable to ask for it – she waited for it to be offered. She used an empty yoghurt carton for her capsule, and decorated it with “jungle print” wrapping paper (Figures 18

[^38]: This was suggested to me by a team-building activity I had once participated in, the “great egg drop”, in which the team had to build a “space capsule” for a real egg, which keeps it safely intact when dropped from the top of a building.
and 19). This had images of monkeys and leopards on it. Anne added a cardboard lid with a hinge, and packed her container with tissue paper and bubble wrap to keep the egg secure. She wrote on the egg – “Anne’s heart and soul and every part of me” – thereby identifying what needs to be nurtured. Anne glued another monkey image and 2 feathers directly onto the egg, “to guard it”.

Anne was happy with her capsule, saying “It all fell into place once I saw the yoghurt carton – its all I eat”. The familiarity of the materials, for example the use of food containers and wrapping paper rather than more intimidating art materials, seemed to reassure her. Anne also appreciated the serendipity/synchronicity of finding the monkey print paper after talking about her toy monkey.

The capsule Anne created reminded me somewhat of a toilet, or a garbage bin, due to its physical shape. I did not share these thoughts, as I did not see them as helpful given the function of the container was to protect a vulnerable part of herself. Also, the exercise had been so controversial for the women, that I was reluctant to bring in another negative aspect. The suggestion of the toilet was, I think, an association to the pig poster, which Anne had brought into group some weeks earlier, and had still not taken home.

**Barb** made a small rose-covered ‘gift’ box and put the egg in a bubble wrap bag inside the box (Figure 20). She said her egg was “in a bed of roses”. She made some string handles and offered to help Anne with her capsule. Barb glued the word “love” to the inside lid of the box, and trimmed the outside of the box with strings of beads. She left early to pick up her niece from school. Despite Barb’s scepticism about the activity, she still did it in good faith, completing it before the following session. She was worried that her niece might put her egg in jeopardy, which demonstrated to me that she was engaging with the task.
Figure 18: “Egg capsule view 1” by Anne

Figure 19: “Egg capsule view 2” by Anne
Weekly Responses

Most Significant Image
Anne: “Writing what I did on the egg”.
Barb: “Seeing how each group member protected their egg, and why we all chose what we did”.

Most Significant Event
Anne: “Letting out aloud that I was not feeling on top at the moment”
Barb: “Discussing the ‘green form’ (handout) and my thoughts and feelings over completing it”.

Figure 20: “Egg capsule” by Barb
Week nine: Self care 2

Attendance

Both Anne and Barb attended. Sandra was absent from this session.

Check-in activity

The initial discussion in this session followed two themes. Firstly, there was further discussion about the final session, and what we would be doing. Anne and Barb had talked about this outside of group, and had ‘joined forces’ to state that they did not want to go to College’s Crossing for their final group. Both of them wanted to have the final group at the centre, rather than in a public place. They were also saying they did not want to upset Sandra, saying “She is the best counsellor, she’ll be so disappointed”. There was perhaps an element of idealisation in their attitude towards Sandra. Realistically, however, the two women would continue to have contact with Sandra after the groups (in individual counselling), so it was important for them to try to ‘protect’ that relationship.

In fact I had been unsure about the notion of going to an alternative venue, and indeed it was Sandra who had initially raised it and continued to do so in spite of opposition from the two women. So Sandra and I had been polarised, or split, and Anne and Barb had become united. I had not voiced my opinion to them, and had been willing to go along with Sandra’s “hunch” that it would be useful to try to push them out of their comfort zone, almost as an enactment of being pushed out of the group when it ended. I agreed that I would discuss their decision with Sandra.

Secondly, they stated that neither of them had done the egg activity (to carry the egg with them for 24 hours) following on from the last group. The reasons they gave were that it was “silly, and childish” (Barb, who had done a similar activity at school) and “mad”
(Anne, who’s mother had said “you’re mad” when she told her about the activity). There was also some questioning of how the activity was related to their eating issues.

This challenge lead to a discussion about the underlying issues raised by the egg activity. For example, many of the sessions had not been about food or eating issues as such, but about the core issues behind these symptoms. I explained that the change of focus from family of origin issues and body image, to self care, was an indication that the sessions were being adapted to their needs, and made ‘less confronting’.

There was perhaps an indication of concrete thinking in this discussion, for example in their difficulty in seeing the egg as a metaphor. However, the egg was not just a metaphor, it also was a real egg. In addition to this issue, there was a sense of rebellion, which I found encouraging, since to me it demonstrated the clients becoming united and challenging the more powerful facilitator, albeit when she was outnumbered two to one! I guessed also that behind the challenge there was an element of fear about the sessions ending without anything having changed.

Anne (the more concrete of the two) stated that “since we stopped doing art the groups have been different”. In fact, there had been only one session (seven) where we did not do art, but perhaps the egg activity had not seemed like art to her, as I alluded to earlier, due to the use of junk materials rather than more conventional art materials. It is not clear whether the comment was negative or positive, but it is perhaps evidence of her ‘splitting’, between the past when we used art, and now when we don’t. The group had of course changed focus and this maybe what Anne was alluding to. Her focus on whether we did art or not may have reflected her anxiety about art, which was clearly still an issue for her.
Art activity: Self-care poster

Continuing the theme of self-care, the task this week was to create a poster which depicted self-nurturing activities they would enjoy doing. These could be made using a collage of magazine images. Both women seemed to find this activity easy and rewarding, in that both of them set about doing it with no protest or apparent difficulty. Anne, who commented that “it all came together so easily”, chose images to represent “accepting compliments, gardening, gym, and massage” in her collage (Figure 21). These were all ways she could nurture herself. Barb’s included “looking at the stars, driving, and listening to music” (Figure 22). Barb had made her collage on two A4 sheets, so she could ‘hide’ it in her folder, to protect herself from her family’s intrusive comments. The posters were laminated and given to the women in the final session.

Handouts

The women were given an anthology of poems by women with eating issues. They also received a worksheet of five questions (“Closure Activity”) for use in the final group (see Appendix D).

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<th>Weekly Responses</th>
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<tr>
<td><strong>Most significant image</strong></td>
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<tr>
<td><strong>Anne</strong>: “How the art work just all came together so eas(ily)”</td>
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<tr>
<td><strong>Barb</strong>: “The picture of the star on my art work because its so shiny and stands out and makes me think more about the things I wish for in my life”</td>
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| **Most significant event** |
| **Anne**: “Being honest about not really wanting to go to College’s Crossing” |
| **Barb**: “Thinking about different ways of nurturing myself while looking through different magazine pictures” |

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Figure 21: “Self-care poster” by Anne

Figure 22: “Self-care poster” by Barb
Week Ten: Celebration

Attendance

All attended this group.

Preparation

Sandra and I had discussed the issue of where to hold the session, and agreed to respect the wishes expressed by Barb and Anne not to go to College’s Crossing, or to any alternative venue. Again we were called upon to demonstrate flexibility in line with the needs of our clients. In addition, it was challenging to us, as facilitators, to plan a celebration without using food or drink. However, we decided to change the environment to reflect that it was the final session, and thought about ways to make this a significant ritual of transition.

It is clear that the short term group had been an important experience for both women, and the ending ritual was planned to reflect this. Vivien Speiser (1998, p. 205) suggests that the role of the expressive therapist may be compared to that of the shaman. Writing about the use of ritual in therapy, she argues that:

Ritual can help individuals begin to remember who they are, where they have been, and to discover their possible direction for the future. (p. 206)

In order to transform the therapy room, we bought helium balloons, streamers, glitter and stars and decorated the room as if for a party or celebration (which it was). We lit candles, turned off the lights and used an oil burner to create a very different atmosphere.

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39 We were influenced here by the concept of a “magic dinner”, which is staged as part of experiential weekends at a local outdoor adventure training centre. This includes going on a blindfold journey, arriving at a room, which has been ‘magically’ transformed, and playing interactive games. Magic dinners, however, usually involve food and drink!
to the previous sessions. We made a sign for the door, saying “Welcome to the Celebration” and put a trail of glitter on the floor outside for Anne and Barb to follow.

Anne and Barb received their posters, which had been laminated. They also received the balloons, and a small gift of Body Shop products from myself as a thank-you for participating in the research. Our original idea was for the women to use the helium balloons to symbolically let go of something that was holding them back, by writing it on a slip of paper, attaching it to a balloon and letting it go. In the event, neither of the women could identify something they were ready to let go of, so they took the balloons home instead.

We had another discussion about College’s Crossing and their fears of upsetting Sandra. This would be taken back to individual counselling sessions.

Art activity: ‘Hand’ collages

In the previous group, the two women had received a worksheet containing a list of five questions (see Appendix D), which they were asked to complete for this week. Their written responses formed the basis of the hand collage.

The collage was made by making coloured cardboard cutouts of their own hands as a base for writing messages to themselves and to others, to take home. Each of the five points from the worksheets was written on one of the fingers, using metallic pens, and embellished with stickers and decorative shapes. The finished hand collages seem to parallel the initial group images created in the round robin, since both art works involved group input, and together they created a satisfying symmetry to the beginning and end of the groups.

Neither Anne nor Barb was able to identify something they were willing to let go of, although Barb had thought of something prior to the session, and forgotten it again. Barb
generally seemed more positive now, and said she got a lot from the sessions. Anne however was saying things were now worse. It was not however surprising that her tendency to ‘catastrophise’ would surface at this time. She related strongly to a poem given out in the previous week, entitled “Healing” (see Appendix F). This poem is about letting go of the eating issue, and it reflects Anne’s ambivalence very nicely, particularly in the final line “I just couldn’t do it today”. Despite Anne’s negative response, it was clear to Sandra and I that she had gained a great deal from the sessions. In the post-group questionnaire, in response to the question: “Did these groups meet your needs?” Anne answered: “Yes. It did make me more aware of my problem. More than I was before”. However, insight into her problems is not all she gained. In particular, her spontaneous risk-taking in terms of self-disclosure, and being occasionally ‘pushed out’ of her comfort zone, had resulted in growth, which she was however hesitant to admit publicly. On my hand collage, Anne wrote the following message: “Thanks for helping me find the strength to ‘grow’”.

Both women responded positively to the hand exercise. It gave a sense of completion to the sessions, as it encapsulated where they had come from, where they were now, and where they were going, in one image. They also valued their completed artwork, with its messages of support from the other women including myself and Sandra.
Weekly Responses

Most significant image
Anne: “Writing messages to the other people on the hand”.
Barb: “Our hands on the cardboard, they are really bright”.

Most significant event
Anne: “Know(ing) that it was the last session was very disrupting”.
Barb: “Writing messages on each others ‘hands’ as a closing (activity) was really rewarding”.

Summary of chapter seven

This chapter has presented case material from a ten week group for women with eating issues. In the following chapter I will examine the results of the project, particularly in terms of how the women responded to specific art therapy interventions within the context of a feminist informed, community based organisation. This will be followed by discussion and evaluation of the study in chapter nine.
Figure 23: “Hands for support”
Chapter eight: Results of study

8.1 Introduction

In this chapter I will examine the case material, from the dual case study presented in the previous chapter, in terms of how two women with eating issues responded to a range of art therapy interventions within the context of a feminist informed, community based organisation.

This will be addressed in the following ways. First, by consideration of Anne and Barb’s responses to the weekly questions about significant art work and significant events, in relation to the “therapeutic factors” suggested by their responses, as well as those identified in the art and group therapy literature. Second, I will examine their pre, mid and post group questionnaire responses, which asked questions about their eating issue, body image, expectations of groups, use of art therapy, feminist model, satisfaction with workers and the “miracle question” (Jacob, 2001). The art work and the group process, which were described and presented in the previous chapter, are also considered in terms of results, in that they provide additional data with which to understand the art therapy process.

The main tool for collection of data was the use of open-ended and scaling questionnaires. Yalom (1985) expresses some reservations about the questionnaire method, if it is used in isolation, arguing for in-depth interviews with the client to be administered as well:

Paper and pencil or sorting questionnaires provide easy data but often miss the nuances and the richness of the patients’ experience. The more the questioner can enter into the experiential world of the patient, the more lucid and meaningful does the report of the therapy experience become. To the degree that the therapist is able to suppress personal bias, he or she becomes the ideal questioner: the therapist is trusted and, more than anyone else, understands the inner world of the patient. (p. 3)
However, perhaps the images in art therapy can serve to provide some of the “nuances and richness” of the clients’ experience, that would be missing if questionnaires were indeed used in isolation.

8.2 Weekly questions about significant artwork and events

Immediately after the art therapy session each week, the women were asked to complete two open-ended questions about their perception of the “most significant image” and the “most significant event” in the group that week (Bloch et al., 1985; Gilroy, 1995). Yalom (1985) describes this method as “the critical incident approach” (p. 546 [footnote]). These questions were aimed at uncovering the therapeutic factors from the clients’ perspective. I shall consider their responses to the two questions in turn, starting with the question about the artwork. All the comments made by Anne and Barb in the following sections are quoted directly from their responses to the weekly questionnaires.

The most significant image (MSI)

In relation to the question of what the respondents consider their most significant image, I propose to examine that question in relation to the following categories: *process of art-making; image resonated with thoughts and feelings; image resonated with self; related to other person’s artwork; and awareness of self and others*. These categories are not mutually exclusive, and were suggested by the responses made by Anne and Barb, which seemed to fall naturally into these categories. Since they were derived from the comments made by the participants, research with a different group of participants may yield a different set of categories. These categories may however be helpful in starting to think about different ways of looking at images created in art therapy, or from an art therapy perspective, in the same way that Rose (2001) suggests we use a variety of criteria for looking at aesthetic images. I did not see it as appropriate for example to use
Waller’s (1993) categories of therapeutic factors in art therapy, as these relate too specifically to her non-directive, group interactive model and do not seem broad enough to apply to other art therapy group models.

If we return to Rose’s (2001) model, she proposes that in looking at images, we consider three sites: the production of the image, the image itself, and the audience. Thus the process of art making, the image itself, and the response of the audience (other group members) will be included in this examination of the research results.

*Process of art-making*

The *process* of art-making was identified in several of the women’s responses. For example, after the “round robin” activity, Anne said the most significant image (MSI) for her was: “doing the round robin artwork as it brought up some memories of my past”. After the group in which we created the “image of the eating issue”, Barb wrote that the MSE (most significant event) for her was: “just playing with the clay. Squishing and moulding it in my hands”. After the “self care poster”, Anne wrote that the most significant aspect of the art work was “how the art work just all came together so easily”. Anne further identified two instances when writing on her artwork was the most significant aspect: when she wrote on her egg, and writing on the hand collages in the final week.

These comments lend support for the contention that the *process* of art therapy is partly responsible for the therapeutic benefit. This seems to have been particularly true in Anne’s case, perhaps due to her fear of doing art, and her focus on the art-making as a result. When she was successful in her terms, her relief was great, and this appeared to have contributed to her feeling of satisfaction.
Image resonated with thoughts and feelings

This category of therapeutic factors in relation to images addresses the relationship between images, and the client’s feelings and thoughts. Anne stated that her MSI was: “doing the round robin artwork as it brought up some memories of my past”. On her image of her eating issue, Anne wrote that her MSI was “the picture I had of inside a person’s head, how it can give out so many negative messages”.

In week one, Barb identified her “round robin” image as the MSI: “the completed image really portrayed the way I was feeling after the session – confusion, spacey, lots of thoughts and feelings about my eating issue”. On the ‘powerful/powerless collage’ as her MSI, Barb wrote: “I could really think about the things in life that make me feel powerless in particular. It left lots of thoughts swirling around in my head”. Sometimes the images sparked off feelings that were mentioned in the MSE responses. After the “animal self portrait”, for example, Barb wrote that the MSE was: “The feeling I spoke about with the whole world seeming so unsafe. Everyone around me. Everything around me.” On a more positive note, Barb wrote that the star image in her collage in week nine was her MSI because: “It’s so shiny and stands out and makes me think about the things I wish for in my life”.

These responses highlight the fact that thoughts and feelings can be expressed through the art work, and demonstrates the importance of emphasising both thoughts and feelings in the art therapy process.

These phenomena do not fit into any of Yalom’s (1985, p. 72 [footnote]) eleven categories of curative factors, but he acknowledges this in a study in which was added a twelfth factor, self-understanding. Self-understanding relates to the acquisition of insight, which is a key concept in psychodynamic psychotherapy (Bloch et al., 1985). This will be discussed further in a subsequent section of this chapter. In art therapy, self-
understanding suggests a dialogue between the self and the image, and as such represents an intrapsychic phenomenon, which is also related to the following category.

*Image resonated with self*

This category refers to images which an individual has a strong personal response to. The person responding is not necessarily the person who made the image. Both Anne and Barb, for example, had a strong response to the pig Anne drew in the third session. Barb wrote that: “its eyes seemed to glare at me as if it was calling out to me”. Anne simply stated that “my pig” was her MSI.

Anne’s poster of the pig, upon which her drawing was based, which she brought to the group in week four, also became an important ‘icon’ in the group for the women. The poster expressed the women’s feelings of self disgust in an acceptable, humorous form, allowing them to be more distanced from their own self-loathing, and to therefore be more critical of it. Anne’s decision to bring the poster to group was a significant symbolic act which, she stated, represented her attempt to reject the negative thoughts and feelings aroused in her by this poster. The only way she could do this was to physically remove the poster from her house and leave it with the group, which could perhaps be seen as an example of her ‘concrete’ thinking.

Barb identified strongly with the candle she created as an image of her eating issue. She identified it as her MSI and stated: “I just want to melt away. To stop having to think anymore”. This comment was concerning, as it may have indicated a potential suicide risk. However, the fact that Barb did not in fact self-harm or attempt suicide may also have been partly due to her expression of these self-destructive feelings and thoughts in group. Wadeson (1987) describes how she would ask a client to make an artwork about the “precipitating conditions for treatment” (p. 27) primarily as an assessment tool.
However she found that “often…the tasks served treatment functions as well” (p. 28). In this case the candle sculpture seemed to have had a cathartic function for Barb.

These instances such as the pig picture and the candle sculpture seem to me to be examples of Schaverien’s (1989; 1992; 1995) concept of the “embodied image”, in which the image “will have substance and convey a tension” (Schaverien, 1995, p. 142). Schaverien writes about the image’s seductive aspect, which means that although the image may be “raw, untamed and sometimes unnameable” (p. 142) it “may still evoke feelings in the viewer and provokes a response” (Ibid).

The artworks’ resonance with self may be particularly important for women with eating issues, who often have a fragile sense of self. It may offer them a window into their own experience, which is otherwise unavailable.

The focus on the self was a key theme running through the group program. This was apparent in a number of ways. Specific activities addressing the self and identity included the “self portrait as an animal in a safe and unsafe place”, the image of the eating issue, the egg in a capsule, and the self-care poster. This will be discussed further in the following chapter.

Related to other person’s artwork

This category specifically identifies images that one person makes, but that another person relates to as their “most significant image”. As we have already seen, Barb had a strong response to Anne’s pig drawing. Anne identified one of the collaged images in Barb’s “powerful/powerless” image as that week’s MSI, saying: “Barb’s picture of the man and the woman, as she said that he looked as though he was the most powerful”.

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Anne also related to Sandra’s megaphone in week five as her MSI, saying “its like we all have one at times”.

Anne seemed more inclined to relate to the work of others than did Barb. Generally speaking, Anne was more focused on her interaction with the group, whilst Barb was preoccupied with her own internal dialogue.

Thus, one of the benefits of art therapy group work may be identifying with the artwork of others. Similarly, Foulkes (1964, p. 34) referred to a “mirror reaction” in group therapy, in which an individual recognised and resolved his or her own issues in their identification with the issues of others. This in turn relates to the therapeutic factors of interpersonal learning and universality identified by Yalom (1985). The art work seems to provide additional opportunities for this process to occur. At times, as has been suggested, the art work may become an “embodied image” for the whole group. The value of the art therapist making art in the group may therefore be enhanced through this factor, since this would provide more images which others could potentially relate to.

Awareness of self and others

This section, which is similar to the previous one, captures comments in which the person responds to an interpersonal issue through the medium of the artwork. Thus Anne identified her MSI as “writing messages to the other people on the hand”.

Barb’s MSI which indicated awareness of others occurred in week eight, when she wrote “seeing how each group member protected their egg, and why we all chose what we did”.

These comments relate to the social benefit of art therapy groups, which were still noted despite the small participation numbers. Anne’s comment is an example of “altruism”
and Barb’s an example of “interpersonal learning”, both being example of common therapeutic factors in groups as identified by Yalom (1985). Thus we can see how the use of art activities can enhance the social benefits of group psychotherapy.

This concludes the discussion on the most significant image. I shall now consider the participants’ responses to the question about the most significant event in the group.

**Most significant event (MSE)**

The question about the most significant event is derived from group psychotherapy research. The aim of the question is to identify therapeutic factors and it has been seen as significant in previous research (Bloch et al., 1985; Gilroy, 1995; Yalom, 1985). The question is based on the assumption that the client’s description of the most personally significant event in the group will help us to identify therapeutic factors as experienced by that individual client. As we have seen in the previous section, these factors can be derived from the artwork process or product. However they may also derive from other events in the group. Common therapeutic ‘themes’ that emerged from this study are noted below. The themes provide a useful tool for discussion of the therapeutic factors that an art therapy approach seems to ‘present’.

**The art making was the most important event**

Many of the MSE responses also related to the art work, and feelings arising from making the images. Barb for example mentioned the strong feelings she had from “playing with the clay”, and, in a later session: “thinking about ways of nurturing myself while looking through different magazine pictures”. It is important to note that this
question was open-ended, yet it still elicited responses identifying the significance of the art-work.

*Self-disclosure, or catharsis*

Anne frequently mentioned self-disclosure as the most significant event in the group. For example: “It took a lot out of me to tell everyone I was a lesbian”; “sharing my innermost feelings with the other members”; “being so honest about how to get the (negative) messages as mentioned above and also sharing my journal”; “that I got through the afternoon without sitting on my chair. Also reading my journal”; “letting out aloud that I was not feeling on top at the moment”; and “being really honest about not wanting to go to College’s Crossing” (6/10 responses).

In week four, Barb said her MSE was “discussing the journals. Even though I hadn’t written much it was a relief to talk about what I had written”.

*Self-understanding or insight*

Barb frequently mentioned her thoughts (and to a lesser degree, her feelings) in five out of nine responses (Barb missed one session): “Brainstorming hopes and fears for the group. It left a lot to think about.”; “the feeling that I spoke about with the whole world seeming so unsafe. Everyone around me. Everything around me”; “thinking about ways we could nurture ourselves”; discussing the ‘green form’ and my thoughts and feelings over completing it”; and “thinking about different ways of nurturing myself while looking through different magazine pictures”.

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Yalom (1985, p. 45) argues that self-understanding, or insight, can be understood on at least four levels: interpersonal insight (how one is seen by others); insight into interactional patterns of behaviour (recognition of repeating patterns); motivational insight (about why one behaves in certain ways) and genetic insight (historical understanding of the self). Barb’s thoughts do not seem to fit exactly into these categories either. Her thoughts and feelings seem to arise in relation to issues such as setting boundaries in group, feeling unsafe, doing her ‘homework’, and simply thinking about the processes we were asking her to think about, such as self-nurture.

In fact, Barb’s feeling of the whole world being unsafe sounds a little like an existential factor, but it is probably more accurately a cognitive distortion, as existential factors are generally true, for example: “life is at times unfair and unjust” (Yalom, 1985, p. 88), whereas it would not be true to say that the whole world is unsafe, even though it is a true reflection of Barb’s emotional state. It could be seen as an example of “black and white thinking”, or splitting, identified by various authors (see e.g. Levens, 1994a), in which everything is taken to extremes.

An example of insight or self-understanding from Anne occurs in week six when she wrote that the MSE was: “that I got through the afternoon without sitting on my chair. Also reading my journal”.

An interesting difference between Anne and Barb is that Anne was making self-disclosures in the sessions, whereas Barb was often experiencing many thoughts and feelings, without talking about them. This fits with our perception that in the eyes of the facilitators, Anne was gaining more from the groups than Barb. However, in Barb’s terms she was still gaining benefit from these thoughts and feelings. In Beresin et al’s study (1989, p. 120) the authors found that the recovery process involved a great deal of self-talk, and use of diary entries, both of which enhanced self-awareness. Since this
intrapsychic process suggests a ‘hidden’ therapeutic factor (we cannot see any evidence for this), it serves as a further reminder of the importance of asking clients for feedback.

In her study of experiential groups with art therapy students, Gilroy (1995) found that “private perceptions of change in these groups not only differ from but are greater than public perceptions of change” (p. 72). This again highlights the need to listen to clients’ self-reports and to ask for feedback. Barb appeared to be participating at a low level in group, but her weekly feedback, journal entries and later her poems demonstrated that while she was not verbally engaged she was still very involved in the life of the group.

Riley (2001), in her chapter on adolescent art therapy groups, includes the following comment by a participant, Kelly:

Art was my vehicle of communication. Even though there were times my message wasn’t getting across to my therapist, I was getting it out of me and my head. Once it was down on paper, it became easier to see my troubles weren’t so scary and that knowledge allowed me to begin to open up verbally. (p. 154)

In this quote, the process of putting the “message” down on paper increases the effectiveness of therapy, highlighting the benefit of “externalising the problem” which art therapy shares with narrative therapy. It has been argued earlier in this thesis that self-understanding is a particular problem for women with eating issues and this suggests that this therapeutic factor is highly significant for this client group.

Interpersonal learning

Examples were cited of interpersonal learning in the group, in which participants were able to identify incidents which increased their awareness of self and others. Barb, for example, after the second group, said her MSE was “the discussion at the beginning of the group regarding feelings and how we all work together to keep this a safe group”. In
week three, Anne identified “how much connection as in feelings were the same (as each other’s) this week”.

As discussed in the previous session, interpersonal learning also occurred in relation to the artwork.

Summary of weekly questions

In summarising the use of the weekly questions, it is clear that this exercise provided the research with a great deal of useful information about the clients’ perception of the art therapy process, and about the groups in general. Yalom (1985) states that “research has…shown…that the therapeutic factors valued by patients may differ greatly from those cited by their therapists or by group observers” (p. 3). The first question, about the MSI, provided clear examples of how the participants gained benefits from the art activities, and the different processes at work in art therapy. In some cases, the art-making process was most significant. In other cases, the images provoked thoughts and feelings which could be worked through verbally. The women responded to their own images and each others. The fact of making art in a group also introduced social benefits.

The second question on the MSE also provided useful feedback on the group process. Self-disclosure was identified as being the most significant factor for Anne. Barb most frequently identified her thought processes (in relation to the events in the group), and the self-understanding that followed, as being most significant. Art making and journal writing were also identified as most significant events at times.

The weekly questionnaire was a simple measure to implement which did not interfere with the clients’ participation, and may indeed have been beneficial in that it asked them to reflect upon the group immediately after it was over. In a large group the use of these
questions would have the potential to generate a large amount of qualitative information about the clients’ experience of an art therapy group. In this case, if less material was required, it would be feasible to take sample responses from the early, mid term and closing stages of the group process.

8.3 Pre, mid and post questionnaires

These questionnaires were administered before, during and after the series of groups. The purpose was to gain an overall impression of the impact of the group, and as a complement to the more specific information collected weekly. Some questions were duplicated to discover if there had been changes over time, whilst some questions were specific to a particular point in time, such as for retrospective assessment of the group. The questions cover the following seven areas: description of eating issue; body image; expectations of groups; use of art therapy; feminist model; satisfaction with workers; and the “miracle question” (Jacob, 2001).

Anne and Barb’s responses to the pre, mid and post group questionnaires are now given in full.

Description of eating issue

Q. How would you describe your eating issue?

In the first set of (repeated) questions, the changes were very subtle. For example, Anne’s first response to this question was “uncontrollable”. This changed subsequently to “out of control” in mid and post group questionnaires. This may have indicated a slight shift in Anne’s thinking, as “out of control” is not the same as “uncontrollable”. (Indeed it may imply that it could become controllable over time).
Barb’s first answer to the same question is as follows:

“I have difficulties eating and drinking in front of others. I regularly go through days of not eating, and whenever I do eat I feel ill, sometimes to the extent that I’m sick.”

In other words, she gives a purely physical description of her eating issue. By mid-group, Barb’s response was:

“As a multitude of feelings/emotions caused by several past events which has made me see food/eating as my enemy, so that I feel ill at the mention of food, my weight and me.”

Barb is starting to relate her eating issue to past events and feelings. In her post group response she writes:

“I find it difficult to eat in front of others. I continuously feel guilty when I eat and prefer to make myself sick than feel so guilty.”

By now, Barb seems to now be more aware of her feelings in relation to her eating, and is able to name her guilt feelings for the first time. She still writes about “finding it difficult” to eat with others, but this seems now to realise that “making herself sick” is a choice she makes as a way to avoid feeling guilty.

Neither of the participants displayed denial of their eating issue, since they had voluntarily chosen to attend a group for women with eating issues. A group in a medical setting might have a different response. However, both did become more open about their emotional issues over the course of the groups.

The next three questions addressed the issue of body image distortion.
Body image

Q. How would you describe your body? (three words only)

Anne: “fat/out of shape/not eye catching”. (pre and mid)

In the post group, Anne writes: “out of shape/not eye catching”, which is identical apart from the word “fat”. It may be very significant that she no longer describes herself as “fat”.

Barb’s first response was “fat/ugly/and humiliating”; her second response was “fat/ugly/fat”; and her third was “fat/ugly/horrible”. The subtle change for Barb is from humiliating to horrible. The main change seems to be that humiliation is about public shame, in relation to being seen eating. Feeling horrible is perhaps a more personal response.

Q. How comfortable do you feel in your body? (scaling question)

Anne stayed at 10 (“not at all comfortable”) in the first two questionnaires, and then moved slightly to about a 9.5 in her third response. In all three responses, Barb stated she felt she was a “10”. In the mid-group she was off the scale.

Q. Where in your body do you feel ok?

Anne consistently picked her ankle as feeling ok, and her lower torso (abdomen) as not feeling ok. A Psychology Today poll (D.M. Garner, 1997) into body image found that seventy one percent of women identified their abdomens as their least liked body part, which was the highest score for any single body part. The area Anne circled as not feeling ok changed in size, however, from directly circling the area below her breasts to include her pelvis, to a larger circle encompassing her forearms, upper thighs and breasts (mid-group), and finally to a much smaller, flatter oval focused more specifically on her stomach. This may have been insignificant, but it could also confirm the facilitators’
observation that both women seemed to be feeling worse in the mid-group period than either at the end or the beginning, and that Anne seemed to be feeling marginally better by the end of the groups.

**Barb** on the other hand consistently could not pick any part of her body that felt ok.

Clearly both women began, as indicated by their responses to these three questions, with very poor body image and this did not change much during the groups. Beresin et al (1989, p. 123) found that body image distortion, along with thoughts about eating and food, was one of the most persistent features in recovering from anorexia.

*Expectations of Groups*

**Q. What do you specifically hope to gain from these groups?**

*Anne:* “No longer have this problem.” (pre)
*Anne:* “To be able to manage my eating issue.” (mid)
*Anne:* “To really become aware of my problem and work hard on a solution.” (post)

**Q. Did this occur?**

*Anne:* “No.”

Anne’s expectations change through the course of groups. Initially, she wants to be “rid of” her problem, then to be able to “manage” it. In the post group, she wants to be “really aware of” the problem, and to “work hard on a solution”. She does not think this has occurred. It is not clear if she thinks neither of these things had occurred, or just “work hard on a solution”. Given that in the answer to the next question, which asked if the group met her needs, she stated: “Yes. It did make me more aware of my problem. More
than I was before” we might reasonably assume that Anne’s “no” indicates she believes she is not “working hard on a solution”.

Q. What do you specifically hope to gain from these groups?

Barb: “I hope to gain a better understanding of my eating issue and to be able to feel ok, and know I am not alone.” (pre)

Barb: “A greater understanding of my eating issue, how it came about (triggers) and how I can work at feeling better at (sic) food/eating in general and ultimately feel ok about myself.” (mid)

Barb: “An understanding of my eating issue.” And to not feel so alone. (post)

Q. Did this occur?

Barb: “Yes.”

Barb’s responses are remarkably consistent across the three questionnaires. Her expectation of “feeling ok” seems to recede slightly from being an initial goal, to being seen as a longer term goal, perhaps. Overall, she feels her expectations have been met. Her interest in finding the origins of her eating issue in mid group is perhaps a reflection of the focus in the group at that point. For example, we were looking at triggers and internalised messages that may have contributed to her eating issue.

The women’s expectations to gain understanding about their eating issues were realistic given the short term nature of the groups. The facilitators were clear that ten sessions was not going to be able to achieve more than this. In other words, the goal of the group was not to ‘cure’ the women of their eating issues. Anne’s initial goal is to “no longer have this problem” but her goal is more realistic by the end of the sessions.

Q. Did these groups meet your needs?

Anne: “Yes. It did make me more aware of my problem. More than I was before”. 279
Barb: “I now know there are many things that caused my eating issue and what I need to do myself to improve”.

Use of art therapy

There were specific questions about art therapy in the pre and post group questionnaires, in order to gain information about the women’s experience of using art in the group.

Q. How do you feel about using art in these groups?
Anne: “I am not an artist.” (pre-group)
Anne: “At times it was very scary.” (post group)

Barb: “Uncomfortable at the start, but I enjoy art, and therefore it will get easier and more comfortable over the course.” (pre-group)

Barb: “Unsure to begin with. I felt silly but as time went on I became more confident.” (post-group)

Q. Has art therapy been a factor in your participation in these groups? How?
Anne: “Yes. It had a way of bringing out issues that would probably have been overlooked if it wasn’t art.”

Barb: “Yes. Art therapy seems to take the emphasis off focusing directly on my issues. It is an easier but still effective way of dealing with feelings etc.”

Anne’s initial response “I am not an artist” reflects both her fear of using art, and the (common) mistaken belief that art skills are important in art therapy. Both women responded positively to the question about using art therapy. Interestingly their answers are different and almost contradictory. Anne describes art therapy as “bringing out issues that would probably have been overlooked”, suggesting she is describing the process of images, and issues, arising unexpectedly from the unconscious, and then being able to be consciously worked on. Barb, on the other hand, sees art therapy as taking the focus away from her issues, enabling her to deal with them more easily.
Interestingly, although a psychodynamic approach was not adopted, both therapeutic aspects of art therapy identified by Anne and Barb are supportive of the psychodynamic approach to art therapy, which focuses on the spontaneous production of images, and on the ability to use them as transitional phenomena, as an indirect way of working through challenging material (Schaverien, 1989, 1992, 1994a).

The following question was intended to elicit an image response to the research question:

Q. Is there one image, or series of images, which sums up for you your experience of these groups? If not, could you create one? (time could be set aside for this).

However, this question was not answered by either of the women, that seemed to suggest it was too abstract/difficult a question for them to be able to respond to. I would have found it difficult to answer myself, although I may have chosen the “pig picture” of Anne’s as the embodied image of the group.

Q. How important was it for you to use art in the groups? (scaling question)


Anne’s lower score perhaps reflects her greater struggle to feel comfortable with the art process. However, both women saw art therapy as a significant component of the group process.

Feminist group model

The following four scaling questions (Jacob, 2001, pp. 25-27), which were all administered post-group, sought feedback on aspects of the feminist therapy model adopted in the group. Thus questions addresses issues which were identified in chapters four and five as significant to a feminist approach, namely: being in an all-women group;
having female facilitators as positive role models; and learning and gaining support from other participants. In all the following scaling questions, 1 is the lowest score (not at all important) and 10 is the highest (extremely important).

**Q. How important was it for you to be in an all women’s group?**

Anne: 10/10 Barb: 10/10

**Q. How important was it for you to have workers as positive role models?**

Anne: 10/10 Barb: 10/10

**Q. How important was it for you to learn from other women in the groups?**

Anne: 10/10 Barb: “We can help/support each other.” 5/10

**Q. How important was it for you to gain support from other women in the groups?**

Anne: 10/10 Barb: 10/10

In terms of the “feminist model” questions, the women marked consistently highly. The only exception is Barb’s 5/10 regarding learning from other women in the groups. This may be a reflection of the fact that there was only one other participant to learn from in this group.

It is interesting to note that it was clearly more important for the women to be in a women’s group than it was to be in an art therapy group. This outcome could be overlooked if the focus was entirely on the art therapy and not on other aspects of the group.
Satisfaction with workers (mid and post group)

The following two questions sought feedback on the participants’ experience of the co-therapists.

Q. (mid) What could the workers do to improve their role in the groups?

Anne: “They are both doing a great job.”
Barb: “Nothing, they’re great!”

Q. (post) How could the workers have improved their roles in the groups?

Anne: “They were excellent.”
Barb: “Nothing. They were both great.”

The participants gave consistently “top marks” to the workers. There may well be a hefty amount of positive transference involved in this rating, in, for example, not wanting to upset us or disappoint us by giving us less than perfect marks. As Duncan et al argue, “clients are often reluctant to communicate negative feelings and their dissatisfaction” (Duncan et al., 2004, p. 64).

However, we cannot discount the fact that both women expressed very positive attitudes towards Sandra and myself as therapists. Unfortunately, as Duncan et al (2004) have argued, “clients’ perspectives regarding therapy and the therapist frequently wind up on the cutting room floor” (p. 63). This is despite the fact that “the alliance data suggest that therapy works if clients experience the relationship positively, perceive therapy to be relevant to their concerns and goals, and are active participants” (Ibid).
The miracle question

The purpose of the “miracle question”, derived from solution focused therapy, is to ask clients to focus “on what life will be like when the problem is more manageable or has been resolved” (Jacob, 2001, p. 21).

Q. (pre) If you woke up one morning and discovered that a miracle had happened and you no longer had this eating issue, what would be better?

Anne: “Having rid of my other problems as well.”

Barb: “I’m not sure what would be better because I can’t remember what it was like not having an eating issue. It’s part of my life right now.”

This question proved a difficult one to answer. Anne clearly cannot see her eating in isolation from her other mental health issues. Barb cannot even imagine not having her eating issue; it has taken over her identity, as was illustrated in Bridget’s image of the harpy figure (figure 1). This use of the miracle question (Jacob, 2001, pp. 21-25), which is derived from solution focused therapy, was apparently not helpful therapeutically, as neither of the women were able to explore the possibilities this question opened up. It is, perhaps, a question better suited to asking face to face, as more prompting and encouragement may elicit a fuller response. However, we also cannot discount the possibility that despite their difficulty in replying, Anne and Barb may have taken away a positive thought from this question, namely that they may not have this problem for their whole lives.

8.4 Overview of results

In this chapter I have presented the written data provided by the participants in relation to their attendance in an art therapy group for women with eating issues. This has been discussed in relation to the therapeutic factors which were originally identified by group
psychotherapists, and in relation to their art work in particular. In the following chapter I will discuss the issues arising from this research, and the implications these issues have for future art therapy interventions with women with eating issues.
Chapter nine: Discussion and evaluation

9.1 Introduction

The previous chapter presented the results of a short term, community-based art therapy intervention with women with eating issues. This art therapy intervention was designed to address a number of issues that were identified as problematic from a critical reading of the art therapy literature. These issues included: the narrow focus of a psychodynamic perspective; the lack of clients’ voices or demonstrated effectiveness; and the scarcity of a feminist or socio-cultural perspective in art therapy approaches to date with this client group (M. Wood, 1996, p. 18). The art therapy intervention that was developed and evaluated for this study was informed by a variety of therapeutic frameworks, including feminist therapy; solution focused therapy, and cognitive behavioural therapy, and attempted to offer an alternative, more client-focused and more socio-culturally aware form of art therapy.

This chapter will discuss and evaluate this intervention, in relation to the art therapy literature discussed in chapters two and three. The framework I have used for this discussion is to consider how the issues identified as missing from the art therapy literature have been addressed in this study. This chapter will also revisit the points raised in the art therapy literature, and discuss whether the claims made by art therapists can now be justified in relation to working with women with eating issues.

I will first consider the issues which were largely missing from this literature, and discuss how these issues were addressed in this project.
9.2 What is missing in the art therapy literature?

In chapter three, the following issues were identified as missing in the art therapy literature: clients’ voices; demonstrated efficacy of art therapy; the socio-cultural context of eating issues; the examination of the treatment milieu; the art therapist’s presence and role; and the consideration of alternative theoretical approaches, including a feminist perspective (M. Wood, 1996). These issues will now be explored in turn, with a view to determining the extent to which this project was able to address these concerns which had previously been overlooked.

Clients’ voices and the effectiveness of art therapy

Perhaps the most important goal of study was to develop and trial a research methodology which would enable clients’ voices to be heard. It was identified in the critique of the art therapy literature in chapter three, that art therapy with women with eating issues was thought to be beneficial, but this thought was largely unsubstantiated, except by assertions by art therapists (M. Wood, 1996, p. 18). The clients’ perspective of therapy was largely absent, which is surprising since the client may be in the best position to give feedback on her experience of therapy. In her introduction to the description of her study into the effectiveness of art therapy in a therapeutic community, Nowell Hall (1987) states that:

In practice, the people best qualified to comment on the effectiveness of art therapy, and the only people who can really understand, are those who have directly experienced it. (p. 157)

In this project, the process which enabled the clients to comment on their experience of art therapy, was the use of two measures: the weekly questionnaire, and the pre, mid and post group questionnaire.
The use of these two measures provided the researcher with a wealth of feedback on the images produced in art therapy activities, on the creative process, and on their experience of the group as a whole. Clearly, the process for these women was often difficult and at times even seemed impossible. However, both persisted, and their overall evaluation of the process was very positive. As discussed in the previous chapter, both women stated that they gained in self-understanding and that their needs had been met.

The participants’ specific comments on the use of art therapy, in the post-group questionnaire, were also positive. Anne stated that the use of art therapy “had a way of bringing out issues that would probably have been overlooked”, and Barb said that art therapy “seems to take the emphasis off focusing directly on my issues. It is an easier but still effective way of dealing with feelings”. Both of these comments provide us with a client’s perspective of the unique qualities of art therapy. This is in contrast to their fears at the outset of the groups, in which Anne said “I am not an artist” and Barb stated that she anticipated that she would find using art therapy “uncomfortable”, at least to start with.

Feedback from the weekly questions of the most significant image (MSI) and the most significant event (MSE) provided confirmation that the process of art-making, as well as the finished image, was very significant for the two women. Art-making could revive memories, evoke strong feelings, and ultimately provide feelings of satisfaction. Images created in the group were able to: reflect troubling states of mind; provide clarification of issues; inspire hope; offer valuable insight into oneself and enhance identification with others.

Other (non-art therapy) elements of the groups which Anne and Barb identified as particularly positive or beneficial included: self-disclosure; psycho-education in regard to eating issues; the use of journals; the use of a feminist model, and the facilitators’ role.
Overall, Anne and Barb’s feedback via the two measures confirm the value of this art therapy project. It is likely that the collection of this data itself enhanced their experience of the group process. Duncan, Miller and Sparks (2004) argue that “gathering valid and reliable feedback about the process and outcome of their clinical work and then using that data to inform therapy” improved outcomes by “up to 65 percent” (p. 15). In their description of their outcome rating scale, which requests feedback on four scales from clients after each session, Duncan et al., state that:

Counsellors have to be on board with two things: first, they have to think that privileging the client’s perceptions, ideas and experiences is a good thing. If the mental health professional does not value the client’s perspective first and foremost and believe that the client should direct the therapy and be an active participant in the decisions that affect them, then the outcome process will have no impact. Second, the therapist must want to be accountable to the client most of all but also to the system that pays for the services. Part and parcel of this idea is that services are precious commodities and should be used wisely to ensure that all who want services will have access to them. Continuing to see clients in the absence of benefit is a tremendous waste of resources. (p. 97)

The use of client’s feedback not only provides valuable data to the therapist; therefore, it also gives the client the clear message that their opinion is valued and respected. This message in itself is likely to be experienced as affirming and therapeutic to the client. Duncan et al., (2004) argue that use of outcome rating scales have the potential to revolutionise the practice of psychotherapy to the extent that “mental health professionals will have proof of the effectiveness and value of day-to-day clinical work and will no longer need to rely on the medical model for legitimacy” (p. 118).

In fact, as the feedback from clients demonstrates in this study, we will note that many of the claims made by art therapists, regarding the benefits of art therapy for women with eating issues, can be substantiated. My initial critique, based in part on Wood’s findings on the British art therapy literature (1996, p. 18), and also on my own reading of the American literature, was not to suggest that art therapists were “inventing” claims for efficacy, but rather that they did not have enough evidence for these claims. Their claims were no doubt based on observation and clinical experience, but clearly something more
was required in terms of validation. The simple measure of asking for client’s feedback enabled me to substantiate many of the claims made in the art therapy literature, as will be discussed in the later section of this chapter.

Socio-cultural issues

As previously noted in chapter three, the majority of the art therapy literature has not addressed socio-cultural issues in relation to the development and understanding of eating issues. This omission closely aligns art therapy with the medical model. As Bordo (2003, pp. 45-69) in her article “Whose body is this?” has noted, the medical model has resisted recognising the importance of understanding eating problems from a wider perspective than the individual client and her family, i.e. the socio-cultural context that has a significant influence upon our construction of ourselves.

The broad category of socio-cultural issues includes an examination of the following areas: the socio-cultural environment in relation to eating issues, especially with regard to gender; the treatment milieu; the role and behaviour of the art therapist; and the theoretical approach taken (M. Wood, 1996, p. 18). The first area can be described as a “macro” feature, since it addresses the wider socio-cultural perspective, whereas the remaining three issues can be understood as “micro” features of the therapeutic process. These features will now be addressed in turn, in relation to the art therapy research project undertaken.
The socio-cultural environment in relation to eating issues

*Frontline* asked Alexandra Shulman, editor of British *Vogue*, if the fashion industry felt any responsibility for creating the impossible-to-achieve images that young girls measure themselves against. Shulman shrugged. “Not many people have actually said to me that they have looked at my magazine and decided to become anorexic.” (Bordo, 2003, p. xiv)

Clearly, eating issues do not occur in a cultural vacuum. In fact, as Susan Bordo (2003, pp. xiii-xxxvi) describes, in her preface to the new edition of *Unbearable weight: Feminism, Western culture and the body* - significantly entitled “In the empire of images” - the impact of the socio-cultural environment on women is mainly via the use of images. This environment, in which eating issues develop, namely Western societies, is characterised by a plethora of imagery in the popular media and advertising, which reinforces a particular female body-type over and over again. The silence of art therapists on this issue, and its role in the development of eating issues, is particularly surprising, given the visual nature of this phenomenon. It is as if art therapists’ focus has narrowed so far that the impact of images can only be assessed from within the clinical setting.

As we have noted in chapter three, the majority of the art therapy literature on eating issues does not address socio-cultural issues in any depth. Whilst their lack of socio-cultural perspective is arguably not as negligent as Shulman’s, art therapists have traditionally taken a narrow view of therapy which pays little more than lip service to the broader environment. Schaverien (1995), for example, states that she agrees “with the view that there is probably little difference in the aetiology and treatment of the male and female anorexic” (p. 49).

The project attempted to address social and cultural issues in a number of ways. The principle socio-cultural factor to be addressed was that of gender. This was addressed first: by the location of the service in a feminist agency which provides community services for women. Second: the facilitators adopted a feminist perspective, by, for
example, seeing eating issues on a continuum (Brown, 1993) and, also by adopting a particular role suggested by feminist therapists, namely that of flexibility, transparency, and self-awareness - especially in regard to eating issues of their own. Third: specific activities were programmed into the schedule to raise awareness, and enable discussion, of gender issues.

Examples of such activities include the “powerful/powerless” collage, the “harpy” activity, and viewing the Kaz Cooke video Gorgeous (1994a). Supporting material was also given as handouts and cartoons, which addressed women’s role and investment in eating issues, and offered a feminist alternative to the participants’ own stories of eating and body image. In addition, the use of collage using magazines pictures offered the opportunity to view and discuss images of women in the popular media, and to use these images in their own artwork.

In the evaluation of the art therapy research group, discussed in the previous chapter, the participants indicated that they valued the feminist approach extremely highly, in terms of being in a women-only group, seeing the facilitators as positive role models, and gaining support and understanding from other women. In fact, this was arguably the most highly rated aspect of the entire program. They also both stated that they had gained in understanding of their eating issues.

**Focus on anorexia as subject**

It was noted in chapter three that in the art therapy literature, the majority of writing about eating issues was focused on anorexia compared to other eating issues at a ratio of approximately 2:1. This was seen to mirror society’s general fascination with anorexia than other “less interesting” eating issues which are less visible, (or less visually arresting); for example, bulimia or compulsive eating. McNulty (1998, p. 23) has argued
that this reflects social attitudes which prefer to focus on women’s deficits rather than on women’s desire.

The research project did not involve diagnosis, and the eating disorders inventory (EDI), was not used, in order to avoid ‘labelling’ the participants. Instead, the women were asked to define their own eating issues, which they did in non-medical terms. Anne described her eating issue with the adjective “uncontrollable”; thereby perhaps indicating her experience of it as a process (over which she has no control) rather than a diagnostic label. Barb’s response was also descriptive:

“I have difficulties eating and drinking in front of others. I regularly go through days of not eating, and whenever I do eat and I feel ill, sometimes to the extent that I am sick”

Barb’s detailed description tells us more than a label of anorexia, bulimia or compulsive eating would convey. Asking women to define their own problems with food gave us more information about the individuals than a mere psychiatric stereotypic label.

The concept of a continuum of eating disorders (Brown, 1993, pp. 53-68), which is an aspect of a feminist approach to eating issues, was utilised, so that the similarities between participants were emphasised rather than the differences. In this framework, all women are seen as having eating issues rather than just those who are within the clinical range.

The treatment milieu

This section addresses one of the “micro” aspects of the socio-cultural environment, namely the treatment milieu. As we noted in chapter three, and as has previously been noted by Wood, (1996, p. 18), the treatment milieu has not been given a great deal of

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40 Or at least, they are seen as more representative of the norm than those who do not. As Brown (1993) argues, “women who are not concerned about their weight are the social anomaly” (p. 53).
consideration in the art therapy literature. The majority of publications focus on medical rather than community settings, but as is the case with gender issues, this significant bias is not discussed. In relation to the previous point, this may be partly due to the prevalence of writing about anorexia, which is the eating problem most likely to require hospital based treatment. However, given the trend towards community care, and the widespread nature of eating distress amongst women, and, increasingly, adolescents, children and men (Jacob, 2001, p. 35), it would seem important to explore alternative, community-based interventions.

The research project attempted to address this deficit through a variety of strategies. First, by locating the project in a feminist, community-based organisation, the participants were clearly not attending a medical treatment centre, they were not given a psychiatric label (unless they did this themselves), and it was understood that the group was located within an organisation with a critique of power and gender issues. This was apparent from posters, a program of groups addressing issues such as sexual violence, and from the feminist stance adopted by the workers in the agency, including the facilitators of this group.

Second, in terms of the research, the location of the group in a community organisation rendered the project far easier to evaluate, since it was a discrete, time-limited intervention and could be researched in isolation. One potentially “contaminating” factor was Anne’s attendance of an assertiveness training group, which overlapped with the eating issues group for several weeks. In addition, both women continued to have individual counselling with Sandra throughout, as they had been doing prior to the art therapy group. However, compared to hospital treatment, which involves the input of an entire multi-disciplinary team (M. Wood, 1996, 2000), and which is subsequently difficult to assess in terms of individual components of treatment, this project could be researched as a discrete art therapy intervention.
In her survey of the British art therapy literature to date, Wood (1996, p. 18) has noted that “the person, body and gender of the art therapist…have not been discussed”. This omission is partly related to the lack of a feminist approach, since this would emphasise, for example, the importance of role-modelling, self-awareness of body-image (Kearney-Cooke, 1991), and of a gender perspective.

The emphasis placed upon role-modelling by the therapist in feminist therapy is usually not paralleled in art therapy. As we have seen in chapter four, role-modelling is considered very significant in feminist therapy. It is recognised that unlike men, women often do not have a range of positive role models to choose from, making therapeutic change problematic (Waldman, 1999, p. 14). The feminist therapist is therefore seen as having a particular responsibility, which is quite unlike the concept of a “neutral” and “blank screen” psychotherapist. The traditional psychoanalytic approach plays down the importance of individual aspects of the therapist, and focuses instead on the “images” that the client projects onto this blank screen via the transference. A feminist approach highlights the need for an alternative: there is almost a requirement for a positive transference, in which the image of the therapist is internalised by the client, as well as the therapist being “a separate subject in her own right” (Ibid, p. 11), through role-modelling.

Specific ways in which the facilitators attempted to act as positive role models in the groups, included: participation in art therapy and other activities; sharing of our own experiences where relevant; and, sharing our feminist perspective with the participants. This perspective included the concept of a continuum of eating distress, our view that culture had an important role in the development of eating issues, and as previously discussed, demonstrating acceptance of a wide range of body sizes (including our own and those of the participants) rather than accepting the cultural ideal of slenderness.
Since in art therapy with women with eating issues, we are dealing with both images and transference, it would appear important to consider the impact of the art therapist’s physical presence in the therapy setting. In relation to these clients, the feminist art therapist arguably has a particular responsibility to role model body image satisfaction, in order to demonstrate that this is possible. The female therapist’s body image in art therapy or psychotherapy is not, however, often discussed in the literature. When it is mentioned, it is generally in relation to changing body size in pregnancy (Acharya et al., 1995; Orbach, 1994; ter Maat et al., 1995), which seems to provide an acceptable forum for discussion of this topic.

The following are some observations of my own process in terms of body image, in relation to the eating issues research group, and in relation to the longer term impact this topic has had on me since becoming an art therapist, (or, indeed, since becoming a woman), and in working with women in a variety of settings:

In the context of working in a therapeutic community, I tried to role-model body-image acceptance whilst pregnant in women’s groups – my goal was to demonstrate that I was reasonably comfortable with and accepting of my body, even though it was not what might be perceived to be an ‘ideal’ size according to current cultural ideals. As with other therapists, changing size due to pregnancy seemed to be easier to think about, and to use in therapy, than changing size due to eating more or exercising less.

Ironically, whilst trying to demonstrate body-image acceptance, which I saw as the “politically correct” line, and the line most useful to my clients, I was often actually struggling with negative thoughts about my own body. Despite my political awareness of cultural expectations of women, I was still living in the culture, and was reluctantly having to admit that I was influenced by those expectations. I did not share this conflict with the eating issues group, or discuss them with anyone at that time. However I do wonder whether the participants, who like most women with eating issues, are usually acutely tuned into other women’s body image as well as their own, may have picked this conflict up. Clearly if they did, this may have influenced some of the transference towards me in the group, as well as my own counter transference.
Since the experience of facilitating this group, and realising the contradiction of these issues in my own mind, I eventually decided to try to lose weight (never having deliberately tried to before) and reached my goal weight whilst on leave from this study. Having done this, on the one hand I have felt a sense of achievement, but I have also wondered if I have in some way “let the side down”.

Personally, the negative thoughts about my body have not completely disappeared, even though they are less than before. Despite the feminist line that we need to learn to love the body we have, clearly we may find it easier to love the body we work hard to achieve, especially if it is now more in line with the cultural ideal. This process has made me more empathic with women with eating issues, since it has highlighted for me the difficulty of ever being in a “comfortable” position in relation to body-image.

One the one hand, being “the wrong size”, yet still being able to function as a role model and therapist is a significant achievement, yet we still may be plagued with culturally bound negative thoughts about that “wrong” body. On the other hand, if we take the alternative path, and change our body shape, are we not simply conforming to cultural norms and failing to challenge those norms. The negative thoughts may remain, although they may change.

Clearly there is no correct position or answer to this conundrum. The positive gain (no pun intended) for me, was that this process forced me to confront my denial that these eating issues or body image dissatisfaction had anything to do with me. Again, this could be understood in terms of counter transference towards the women, which I mainly experienced as a sense of protectiveness.

Similarly, feminist academic Susan Bordo (2003) is fully aware of these inherent contradictions when she says: “my analysis of eating disorders…is deeply informed by my experiences as a woman who has herself struggled with weight and body-image issues all her life” (p. 32). She has, for example, described losing weight and encountering criticism from her feminist colleagues as a result (p. 30), highlighting the importance (and difficulty) of role-modelling in the feminist community. Yet even the very term “role-modelling” suggests the manipulation of an image, perhaps that of a person to aspire to, and to be ‘held” by, for therapeutic benefit.

Similarly, the qualities identified as being important in any therapeutic encounter, such as genuiness, empathy, and positive regard (Wadeson, 1980, p. 34), were demonstrated by
the facilitators in the art therapy research group. Duncan et al (2004) argue that Bachelor’s (1995) research has shown that:

Nearly one-half of clients described a good relationship in terms of therapist respect, empathic understanding, and attentive listening; this often included a friendly relationship with the therapist. For another forty percent, improved self-understanding, gained through therapist clarification of client material, characterised a positive relationship. Finally, a smaller proportion of clients viewed the relationship in terms of collaboration…Bachelor’s work suggests that a flexible repertoire of relational stances that suit different clients is important to the efficacy of therapy. (p. 35)

This final point, that of flexibility, will be dealt with further in the following section.

Openness and flexibility of approach

A related issue to that of role-modelling is that of flexibility and openness of approach. The women in the research group were given the topic schedule (see Appendix B) before the groups started, to provide them with information about the activities we would be doing each week. This strategy was part of our deliberate attempt to have an open process. Information about groups is often given orally to participants, but not written down. If clients are nervous, as these women were, they would not be likely to retain information given orally, and this requires a different method of information giving. This relates more generally to the issue of the amount of structure provided in the groups, as previously discussed.

The amount of information given was deliberately limited in terms of details, to prevent the participants from attempting to “prepare” for the activities before the group. Based on the feedback from the women, I would argue that there are both advantages and disadvantages to providing this information prior to group. A supervisor of this study commented that it gave them information on “what to miss”. Personally I do not see this as a bad thing, as the women were attending through choice, and what they did miss may
have had deeper psychodynamic meaning that also could have been discussed. In the event, strategic missing of sessions did not occur, and the only absence (Barb in week seven) was negotiated in advance.

Anne stated in her post-group questionnaire that she did not find this schedule helpful, as she worried more about the activities based on the small amount of information she had about them. This could be interpreted as classic anticipatory anxiety. Barb, on the other hand, said she did find it helpful to have the schedule, as she liked to know what to expect. The different responses highlight the importance of seeing participants as individuals, and of being flexible, as Duncan et al have suggested (2004, p. 35).

In fact this open process did give the participants enough information to enable Anne and Barb to raise concerns about future sessions, and for us to negotiate with them a change in orientation, thus demonstrating our responsiveness and flexibility. This could be seen as “collusion” with the clients’ defensiveness, or “avoidance of conflict”, or any number of critical interpretations. This reaction however would be based on the premise that the facilitators had got the schedule “right” in the first instance, and that the clients were somehow avoidant in their response. Instead, by taking a “client-centred” approach (Rogers, 1961), we were able to demonstrate a willingness to work with Anne and Barb from where they were, rather than where we thought they should be. In their chapter “Becoming client directed”, Duncan et al (2004, pp. 68-71), stress the importance of accepting the client’s goals in therapy, and in “tailoring” therapy to meet those goals, rather than attempting to “promote change by validating the therapist’s favoured theory” (p. 71).

In the questionnaires, the participants were asked to rate their satisfaction with the facilitators. Both women gave the facilitators consistently favourable responses to the question “What could the workers do to improve their role in the groups?” with comments such as: “They were excellent” (Anne) and “Nothing. They were both great”
These responses indicated a high level of satisfaction with the facilitators, which would seem to confirm the validity of our approach.

Theoretical approach

The psychodynamic, object relations-based approach has not frequently been questioned or challenged in the art therapy eating issues literature, and alternative approaches are not often described, particularly in the British literature (M. Wood, 1996, p. 18). One of the major problems with the psychodynamic approach, in relation to this client group, is its narrow focus on the individual and her relationship with her mother, and the resulting lack of a socio-cultural focus. Although object relations is the dominant approach used in art therapy, other approaches have occasionally been documented (Malchiodi, 2003; Rubin, 2001). Rubin, for example, includes Jungian, behavioural, cognitive, developmental and humanistic approaches, as well as the more usual object relations approach, in her comprehensive overview of theoretical approaches to art therapy. Feminist approaches to art therapy have, however, not been frequently noted (one exception is Hogan, 1997a). The research project offered an opportunity to trial a different model, with a view to meeting the needs of the participants more effectively, in part by taking a wider view of eating issues than object relations theory affords.

The major influence informing this approach was feminist therapy, into which cognitive behavioural, psycho-educational and solution focused approaches were incorporated. Other aspects of the framework included: a non-medical approach; and a directive, short term art therapy intervention. Specific alternative strategies utilised included: the use of journals; viewing of the Gorgeous video (1994a); the introduction of other resources such as poems and cartoons; homework activities; and a closure ritual to celebrate the ending of the group. Alternative approaches adopted by the facilitators (which have already been discussed) included: adopting an open style of facilitation; acting as role models;
incorporating a feminist perspective on eating issues; demonstrating flexibility; seeking feedback from clients; and focusing on strengths.

_The process of adolescent development_

As we saw in chapter three, art therapists who use an object relations framework have focused on the symbiotic infant/mother relationship in the early years of life, which they have used as a template for understanding the individual with eating issues in relation to her family. However, in real terms, the struggle the client is going through fits better chronologically with an adolescent phase of development, in which the individual struggles to be free to have a separate identity from the family (Waldman, 1999, p. 11). In fact the dynamic is similar, with the issue in both phases being about separation and individuation, and with the adolescent period in a sense being a re-enactment of the infancy stage.

In the art therapy research group, both women were clearly having difficulty separating from their families. Anne’s issues were manifested in her parents’ ridiculing of her art therapy activities (which she nonetheless chose to share with them), and her need to sleep at her parents’ house when she was too anxious to sleep in her own home. She also talked about a general feeling of lack of entitlement, which had started in her childhood due to growing up in a large but impoverished family, and this was expressed in her anecdote about “sneaking food”.

Anne’s infatuation towards Sandra, which she admitted to towards the end of the groups, may have been an indication of her increasing maturity and separation from her family. It represented a focus away from the family, and although we could argue that Anne saw Sandra, through the transference, as a maternal figure, it was clear that Anne was
identifying her feelings as sexual, having identified herself as a lesbian earlier in the group.

In writing about the “erotic transference”, (in this case, between her anorexic male patient, Carlos, and herself) Schaverien (1995) describes it as “the unspecific and multifaceted desire for connectedness” (p. 44). She points out that “anorexia is essentially the denial of desire” (Ibid) and yet she suggests that her case study can be read “as an example of the desire of the male patient” (Ibid). Schaverien argues that female therapists may be reluctant to admit to feelings of erotic counter-transference towards their patients, and may even repress these feelings: “the female therapist may view her own sexual arousal as inadmissible and reframe it as maternal” (p. 11). This gives an interesting perspective on the predominance of object relations theory in art therapy, since Schaverien seems to be implying that much of the maternal focus of transference may be a denial of the erotic. Waldman (1999) goes further, using Schaverien (1995) as an example of an art therapist who makes “little mention of homoerotic feelings” (Waldman, 1999, p. 11) and suggesting that as Freud (1970) originally posited, “perhaps there is a reluctance by many therapists to examine their own bisexuality” (Waldman, 1999, p. 11).

In the case of Barb, who was significantly younger than Anne, she had described a family in which food was a potent currency. Her mother was a chef, and she, like Barb, did not like to eat. She described her mother as emotionally unavailable, and her role in the family seemed to be one of substitute mother, at least towards her sister’s child. She was a nurturer of others, but not of herself. Barb, like Anne, had a strong sense of lack of entitlement, as can be seen in the following extracts from her journal:

“How can I think of ways to nurture myself when I feel that I don’t deserve to be nurtured? It is so much easier to flow along and agree with the harpy inside, than it is to fight anymore. Besides, I don’t have any energy left.”

And:
“I sit here full of anger towards myself while family members and other close acquaintances remind me constantly of where I used to be and how much of a disappointment I am now. So every day I hate myself that little bit more.

I have tried to tell myself that I really do deserve love, satisfaction, success and respect, but it doesn’t seem to matter how often I tell myself this, my heart doesn’t believe it. Maybe that’s because the people closest to me, my family, don’t believe it. Does this mean I am a bad person?”

Another issue for Barb was the sense that she had started out with great potential and had somehow let her family down, which is clear in the second journal entry above. For Barb, her art work was at times her only means of expression. Barb struggled throughout the groups to allow herself out of the shell she depicted in her first collage. However, it is clear from her written comments in her questionnaires, that she was thinking deeply about what was happening, and was having strong feelings as well, which often were not expressed. Barb had largely a positive response to the group facilitators, although she expressed some possible negative feeling towards me, as an unknown person, in the initial weeks. Overall, Barb had difficulty in feeling safe and in establishing trust, and her presentation reminded me of someone who had been sexually abused.

In fact, both women described abusive relationships they had been involved in. Anne’s was an experience of domestic violence and emotional abuse with a previous partner, which had exaggerated her feelings of being unentitled. Barb had been physically threatened by her older, male cousin when she was sixteen, over her refusal to eat. This had resulted in her feeling of being unsafe. The possible correlation between sexual abuse and eating issues has been identified by some feminist writers (Bordo, 2003; Calam & Slade, 1994). Calam and Slade for example describe themes of women using eating as a way of regaining control after an “unwanted sexual experience”, and of deliberately changing their body shape “to avoid further sexual advances” (p. 102).
Thus, if we use an adolescent developmental framework for understanding eating issues, we see an emergence of important sexual themes in the case material, which an object relations framework may have missed.

The previous section examined themes that were identified as “missing” in the art therapy literature with women with eating issues, and which the art therapy research group attempted to address. The following section will revisit the themes that were mentioned in the literature, with a view to determining the extent to which the current research project provides evidence for claims previously made in relation to the effectiveness of art therapy with these clients.

### 9.3 Consideration of issues identified in the art therapy literature

This section will assess the clinical intervention, in relation to the categories identified in the art therapy literature which are applicable to this project. I will look at the art therapy research group through the lens of issues raised in the art therapy literature, with a view to identifying correlations (or differences) between assertions by art therapists and the findings of this study.

*Autonomy of self and identity issues: Art therapy as self-actualisation*

Bruch (1982) argues that a psychoanalytic approach which focuses on insight for these clients:

...represents a factual re-experience of the transactional patterns that have pervaded their whole lives, namely, that somebody else “knew” what they felt but they themselves did not know or feel it. “Insight” to them had been just one more “thing” they had passively accepted from their therapist but then devalued as meaning nothing. (p. 1536)
In other words, Bruch highlights the need for women with eating issues to begin to focus on their own experiences and feelings, rather than have aspects of treatment imposed on them from outside. This is an example of the importance of working on the self and on issues of autonomy. I will now discuss how these issues were addressed in the art therapy research group.

From the outset, the model utilised in the group was one of self-determination. The women were asked to define their eating issue for themselves, and a non-medical approach was adopted. The issue of autonomy was addressed first, by giving the women choices, and second, by giving them regular opportunities to have input into the therapy process. The group facilitators were flexible enough to change the schedule of sessions in response to the particular needs of these participants.

As was noted in a previous chapter, Bruch (1974) suggested that art therapy in and of itself could assist clients with eating issues in developing a sense of self-worth and efficacy. She sees art therapy as being beneficial in the development of autonomy, since:

Art work and dreams serve to convince him that he does not function only under the influence of others, but that there are things which are truly his own, originating within him, expressing in his own imagery what goes on inside him. (pp. 345-346)

This assertion would apply to all kinds of art activities. Art activities which specifically addressed issues of “the self” included: collage of images I like; self-portrait as an animal; collage of wants and needs; the egg and capsule; and, the self-care poster. In addition, the collage on power, and the image of the eating issue, focused on the particular underlying dynamics of each participant’s problematic relationship with food, themselves and the world.

Anne’s use of self-disclosure in the groups, and her identification of this as one of her most cited MSE (most significant event), in particular her identification of herself as a
lesbian, strongly indicated that she was developing a sense of her autonomous self in the group. Thompson (1994, p. 118) noted that “coming out as a lesbian” was a therapeutic factor for several of the women with eating issues in her multi-racial study, as were related acts which involved self-determination, such as leaving home, and going to college. As reported in the previous chapter, Anne cited self-disclosure as being her MSE in six out of ten weekly responses. The therapeutic factors, in group therapy terms, that were activated by this process were those of catharsis and self-understanding.

Barb similarly used art therapy, and the group experience, to get in touch with her feelings and thoughts, although she did not always choose to share them. As Barb’s journal and her weekly responses indicate, her inner thought process was fully activated by group activities, and this was mainly processed internally rather than shared in group. As we have seen (Beresin et al., 1989, p. 120), the absence of catharsis in not necessarily an indication of lack of self-awareness. Indeed, the intra-psychic focus involved in art-making, where the individual is at times barely aware of other group members, in addition to journal-writing, which takes place outside of the group, may also assist in the stimulation of this therapeutic process of internal self-talk.

*Splitting and polarisation: Art therapy as an integrative process*

The theme of splitting and polarisation did arise at various points in the group. This was most obvious during the discussions about the location of the final group. Also this came out more subtly in the participants’ idealisation of Sandra, with me being seen at times as the bad, scary or alien therapist. Clearly a ‘real’ split existed between me and Sandra. She was an employee of the centre, and already had an established relationship with the women. I was the foreigner, bringing in this strange new food, art therapy. In some ways it was helpful for me to be the outsider, as it may have decreased some of the feelings of alienation of the participants.
Seeing ourselves in relation to the participants, clearly Sandra and I were in a different role, as workers rather than clients, and were not identifying with having serious eating issues. This difference was perhaps alluded to by Barb’s dream in which “all the posh people were sitting at one end of the table” – a comment which reflected the seating positions in the group at the time, with Sandra and me at one end, Barb and Anne at the other. This separation, between facilitators and clients, is a necessary boundary which enables therapy to occur. It is not however about being polar opposites, or unattainably different from the clients, which relates to the emphasis feminist therapist place upon role modeling (Kearney-Cooke, 1991).

Themes of splitting may obscure real differences between individuals. Clearly Anne and Barb had both similarities and differences, both in their eating issues and in their lives in general. In a larger group of women, with a wider spectrum of eating issues and body sizes, these differences and similarities may have been less apparent, but due to the small number of participants, these were clearly experienced and expressed. Perhaps the more realistic split was between these two, who were ready to attend the group, and the other potential participants, who were not. Whilst unfortunate for the ‘other women’, this may have given Anne and Barb some comfort in the acknowledgment of their courage in even being present.

The art activities aimed to address splitting in the following ways, for example: to explore and integrate powerful and powerless images; to integrate images of safe and unsafe places; to reintegrate split-off aspects of themselves, such as self-nurturing, and acting self-protectively; and the more overarching goal of starting see themselves and their bodies as one.

*Body image distortion: Art work as a mirror to the body*
In the art therapy literature, the use of body outline drawings has been identified as a significant method for addressing body image disturbance (Rabin, 2003; Woodhead et al., 1997). This activity was planned for the original program, as I had used it successfully with women in different environments, most notably in long term drug and alcohol treatment.

The responses to the pre, mid and post group questionnaires indicate an ongoing problem with body image for both women. It became clear that these two participants were probably not ready for the body outline activity, as described in the art therapy literature (Woodhead et al., 1997), as they would have found it too confronting. This became apparent from their comments about the session schedule, and the level of anxiety they expressed about some of the other activities. Often their anxiety seemed related to visibility, as in Anne’s fear of art, and the fear of going outdoors to a celebration, which this activity would have highlighted. They also expressed fear of doing different things, out of their routines and comfort zones. Overall, at this point in the group both were feeling very fragile and we did not want to scare them away from the group, so there may have been an element of placating them, for the sake of the group continuing.

The women’s discomfort with even the idea of this activity makes sense when comparing the different treatment milieus, and highlights the significance of the therapeutic context. In the previous setting, the clients were in long term drug and alcohol residential treatment, and they were used to, and required, a much more confrontational style of therapy. They knew the facilitators better and had a greater level of trust established. Anne and Barb on the other hand were going home after the group to less than ideal environments and this was also taken into consideration.

Of course there is also an argument to be made for ‘feeling the fear and doing it anyway’, in the belief that the women would ultimately benefit from the challenge. There is some
merit in this argument and I am certainly not advocating that we avoid encouraging clients to take risks. However, in this particular setting, both women at the time were expressing great vulnerability and our decision should be understood in this context.

I have since used this exercise in community based workshops and conferences, and have found that women who are ready to work on their body image are able to participate readily in this activity. However, it is important to be aware of potentially high anxiety levels which such exercises may engender. We cannot assume that any activity is going to feel “safe” for any individual, and participation should be voluntary.

*Relationship with the mother: Art work as a container within the therapeutic relationship*

Both women were quite enmeshed with their families in general, and over identified with their mothers in particular, which became apparent in their narration of events through the week between sessions.

Anne for example lived with her controlling parents much of the time, despite having her own home. She was very influenced by their critical comments upon her activities, which came to a head during the week of the egg activity.

Barb described her mother as also having an eating issue, as well as being a chef. Barb often took on the parent role in her extended family, by looking after her niece. She did not feel supported by her mother, describing her as “emotionally unavailable”.

Both women were able to identify their families as rigid and suffocating but found it very difficult to change their family relationships. The importance of our roles, in modeling different kinds of relationships, was important in addressing their enmeshment.
In terms of the art work, we did not do specific work on families, except indirectly via the harpy exercise, which identified internalised voices, and by introducing self care as a way of making up for their lack of nurture. We decided not use a family of origin theme, as this like the body image drawing was likely to raise levels of anxiety to unacceptable levels.

The facilitators were available to provide nurture in a less rigid and suffocating manner than in the participants’ families. This issue was not directly addressed in the evaluation questionnaires, except for the question asking about their satisfaction with the workers’ roles. Both expressed complete satisfaction with the workers; however, it may have been too confronting to have expressed a critical view.

*Control/perfectionism: Art therapy as mastery*

Both women struggled with control and perfectionism issues, Anne particularly. She identified early in the groups as having obsessive compulsive disorder (OCD). She struggled with changes in routine, such as someone else sitting in her seat, and with some of the activities where she worried about not being able to do a good enough job, especially the harpy activity, which she found extremely challenging. When Anne was able to complete an activity to her satisfaction, she had a good sense of mastery, saying with delight on one occasion how “it all came together so easily”.

Art therapy was helpful in giving Anne an experience of success in art-making. This was less of an issue for Barb, who was able to have ‘mastery’ over the art materials more readily than Anne.

*Overcoming denial: Art work as a mirror to the eating issue*
This issue was identified in the art therapy literature as being of assistance in creating insight by “holding up a mirror” to the eating issue.

The women had chosen to attend this group, which was clearly advertised as being for women with eating issues, and were therefore on one level not in denial. Barb however was possibly in denial about her eating, as she was apparently overweight whilst claiming not to eat. Anne on the other hand was very upfront and needing almost to ‘confess’ her eating behaviours. There was an element of transference in this dynamic, as it was similar to the way she related to her parents.

An additional benefit of using art to create a mirror to the eating issue is that of externalisation. In this process, the eating issue becomes at once more concrete and more manageable, by seeing it on paper rather than experiencing it. A particular activity designed to address this, was the directive to create an image of the eating issue. The harpy activity was also a way of externalising and representing an aspect of the eating issue, sometimes identified as a negative or critical voice.

Art therapists have written on the use of media and style of art work, relating this to various types of eating behaviours. Both Anne and Barb chose to use collage or drawing on most occasions, which could be seen as materials which are not messy, and which are relatively easy to control. Barb used clay on one occasion and found this to be quite overwhelming. Again these examples perhaps relate to issues of control and mastery. The choice of art media will be discussed in a later section of this chapter.

_Concrete thinking: Art therapy as bridge between inner and outer worlds_

Levens (1994a) in particular has hypothesised that women with eating issues are unable to think in metaphors, and that the use of art assists them to form a bridge between what
is inside, and what is outside the body. This relates to the previous point, as it equates art materials with other concrete materials such as food, and the use of the body as a vehicle for self-expression. The answers to the weekly questionnaires give some insight into the question of whether the use of art therapy assisted the women to bridge their inner and outer worlds.

After the “round robin” activity, Barb wrote that the image “really portrayed the way I was feeling after the session – confusion, spacey, lots of thoughts and feelings about my eating issue”. About her collage of her eating issue, which she depicted as a head with the word “No”, surrounded by “forbidden” items, Anne said she became aware of “how it can give out so many negative messages”. In relation to the same activity, in which she portrayed her eating issue as a candle, Barb wrote “I just want to melt away. To stop having to think anymore”. About the star in her self-care poster, Barb wrote: “It’s so shiny and stands out and makes me think more about the things I wish for in my life”.

These examples seem to me to demonstrate how the images created in art therapy resonated with issues the women were becoming increasingly aware of. However this is not the same as Levens’ (1994a) claim that women with eating issues are unable to think in metaphors. Schaverien’s (1994b, p. 58) concept of the embodied image may be a more useful concept to explain the significance of these images in art therapy.

Active participation

Active participation in therapy has been identified as a key therapeutic factor in working with women with eating issues. In her work with women with anorexia, Bruch (1982) found that: “an approach evoking active participation on the part of the patient lead to better treatment results” (p. 1531). This suggests a rationale for the use of art therapy for these clients.
The process of art making, as well as participation in other activities such as writing, reading from journals, and group brainstorming, were identified as significant by both women, at different stages, as their MSI/MSE in their weekly questionnaire responses.

**Benefits of art therapy groups**

Due to the small numbers this was not a ‘true’ group, but the women still identified some social benefits of their shared experience. They identified that they benefited from being in a group and learning from others. Barb stated that one of her goals was “to not feel so alone”. She thought this goal had been met by the end of the groups.

On a personal level, Anne frequently stated that she benefited from self-disclosure, and the fact that this occurred in a group was probably more significant than if it occurred in an individual session. Anne also stated that she gained in awareness of her problem.

Both women related strongly to the art work they made, to the process of making art, and to the art work of others. Making art in a group is a unique experience which involves being both alone and with others in the group, combining introspection and self-absorption within the safety of the group (Johnson et al., 1999).

**Directive vs. non directive approaches**

The facilitators made the decision to use themes and directives, due to the short term nature and goals of the group. We had specific goals to meet in the sessions, particularly the exploration of what was behind the eating issue, which may have taken longer to arise in a non-directive group.
This strategy finds some support in the literature (D. Waller, 1993). Riley (2001) however argues for spontaneity, suggesting: “do not give preconceived directives to a group or individual in therapy” (p. 24). Instead, Riley prefers themes to arise from discussion with clients. The low number of participants was a factor in us finding structure useful, as it may have been difficult for two participants to generate enough material each week to suggest a group theme (although in fact the amount of material they brought to group was substantial).

The use of directives was successful in that the women were able to use the structure and work within it. What was less successful was the use of directives that had been planned in advance. In this case, we had decided to use a preconceived overall framework, but were flexible enough to change it in response to the needs of the participants. This was a compromise between the non-directive approach advocated by Waller (1993) for longer term groups, and the spontaneous directive approach suggested by Riley. Obviously we were not able to predict the group process, or the individual progress of the participants, and we found we needed to adjust the plan in response to the group’s needs.

It was in itself a successful strategy, however, to openly model flexibility in changing the plan, and discussing the reasons for this with the participants.

Specified themes: Art therapy techniques as “special recipes”

Most of the activities that we utilised were successful. In other words, the participants were able to use the activities to describe the nature of their issues, both to themselves and others, and to begin to explore the issues underlying their eating issues, using visual media. The primary goal of the group was to increase awareness of the participants’
issues with eating and food. Overall, the feedback suggested the groups met the women’s needs.

Some of the themes were chosen to address specific issues. In particular, we chose to focus on the self, and on enhancing understanding of both cognitive and emotional aspects of eating issues. A further theme was to understand the wider socio-cultural milieu, from the family to society as a whole, that had assisted in the evolution of these issues.

The approach to developing themes and activities was to use a variety of sources, to adapt pre-existing themes, and to be creative in thinking about different ways to explore these issues using art therapy. These themes were enhanced by the use of video, cartoons, handouts from a variety of sources and regular use of journal-writing to encourage self-reflection and provide containment between the sessions. The use of journals was not included in the research questions but they were frequently mentioned by the women as being significant. This suggests the combination of verbal and non-verbal methods may be particularly useful with these clients.

The innovative approach to developing resources and directives is recommended for future groups and again demonstrates flexibility and creativity in program planning.

*Interpretation and transference issues*

The use of interpretation was seen as controversial in the practice of art therapy with this client group. However, it will be noted that events have been interpreted in the narrative of the dual case study (chapter seven), although this was not much used in the group. Rather, it was used as an aid to the facilitators in understanding ‘what was going on’. Any direct interpretation of the art work was made by the woman who created it.
In particular, in relation to the transference, Sandra was probably placed in an idealised role with a need to protect her from any negative thoughts. She also became for Anne a symbol of an ideal partner, even though Anne was aware of the impossible nature of the relationship. I on the other hand may have represented the outsider who brought in some strange new foods to the group – the art materials.

**Particular benefits of specific media: Art supplies as “special food”**

In the art therapy literature, various media were suggested as being particularly beneficial for women with eating issues. These included magazine photo collage, clay, mask-making. Some general claims were made by Fleming (1989) with regard to the expressive therapies continuum (ETC), which, she suggests, offers a developmental model for the progressive use of increasingly less “controllable” media over time. Otherwise, the media recommendations appear to be based on the preferences of the art therapist, although the use of magazine photo collage was put forward by both Rust (1987) and Matto (1997) as being particularly relevant for these clients, as it can be used to examine and understand the use of images of women in the media, as part of the process of art-making. Macks (1990) similarly suggests that clay has “healing” properties, as it evokes “archetypal” female imagery. The use of different media does not appear to have been researched with this client group however, and most of the claims made are anecdotal, although the hypothesis for using magazine images is congruent with a feminist approach.

As previously stated, in the research group in this study, the women most frequently used collage and drawing. A range of art materials was made available for each session, and in most cases, specific media were not suggested for specific activities. The exception to this was the magazine photo collage completed in week two. Collage was selected,
bearing Fleming’s (1989) ETC schema in mind, as it was thought to be an easily mastered medium which was suitable for activities early on in the course of groups. Clay was used on one occasion by Barb, in her image of the eating issue. She chose to use clay (the messiest medium) to represent what she felt least control over in her life, which seems to fit with the ETC. Barb had a strong reaction to using the clay, finding it overwhelming.

In general, Anne seemed to be happier with the result when she used collage, as it took away her fear of drawing. For Anne this seemed to be a mastery issue, as she had identified herself as having obsessive compulsive disorder (OCD), and control was a key issue for her, as was evidenced by her wish to always sit in the same seat. Mostly, magazine photo collage seemed to meet Anne’s control needs. The only time Anne worried about using collage, was when everyone else decided to use clay. This was, as she acknowledged, more a fear of being different, than a reaction to intrinsic qualities in the collage.

Paint was only used in the “round robin” activity in week one, and this involved using paint sticks with foam tips, rather than paints and brushes. We did not use video (except to watch), mask-making, or body outline drawing, which as previously discussed, was thought to be too confronting for our clients.

Overall drawing and collage were the most frequently chosen media. These seemed to meet the participants’ needs for mastery and self-expression. However, as we have seen, choice of art media is a personal matter, and it would be generally recommended that a choice of art materials were provided in art therapy groups.
9.5 Summary of chapter nine

In this chapter I have discussed the implications and outcomes from the dual case study described in the previous chapter. I have correlated the results of the weekly questionnaires and the pre, mid and post group questionnaires, with reference to the items that were missing in the art therapy literature, in relation to women with eating issues, and discussed how these gaps were addressed in this study. I have also revisited the claims made in the art therapy literature, and found that in most cases, there was evidence to support these claims regarding the effectiveness of art therapy with these clients with reference to the therapeutic factors identified in the literature. The following issues have emerged from the consideration of the material gathered in the research. They include: the importance of the image in art therapy; the need to utilise alternative theoretical frameworks for art therapy; and the importance of seeking clients’ feedback in our evaluation of our clinical practice.

In the next chapter I will summarise the findings of this thesis and make recommendations for future research.
Chapter ten: Conclusions

Imagine for the first time in history that mental health professionals will have proof of the effectiveness and value of day-to-day clinical work and will no longer need to rely on the medical model for legitimacy...Imagine establishing an identity separate from the field of medicine. It is easy if you try. (Duncan et al., 2004, p. 118)

10.1 Major findings of the research

This thesis has examined the use of art therapy with women with eating issues, using a number of ‘alternative’ frameworks, in particular the adoption of a feminist informed approach. It has taken the existing, psychodynamically informed art therapy literature as a starting point, and has looked critically at this literature, in order to explore the validity of the claims made in relation to women with eating issues, and the utility of art therapy in addressing these issues. From this foundation, the thesis progressed to the identification of critical issues which were not adequately addressed in the existing art therapy literature. These included the consideration of socio-cultural issues and their impact on women, a critique of the medical model, and the inclusion of clients’ voices in art therapy narratives. The thesis then looked at feminist frameworks, and other therapeutic methods for understanding and treating eating issues, and put forward a methodology for a feminist informed art therapy intervention, which was implemented and evaluated. This research was documented and the results discussed in the previous chapter.

I will now outline the major findings of the research. These are as follows, and each finding will be discussed in turn.
The importance of a feminist approach with women with eating issues

This research project has shown the importance of using a feminist framework when working with women with eating issues. The participants, Anne and Barb, like many women, developed eating issues as a coping response to the following: stressful life events, such as domestic violence and emotional abuse; intense pressures from family to behave in certain proscribed ways; negative life experiences; and chronically low self-esteem. For these women, control over food was their only way to feel a sense of control over their lives (Bordo, 2003, p. 68). These issues have developed within a cultural environment which presents images of increasingly slender women in the popular media and advertising, images which ordinary women are constantly exposed to, and measure themselves against (Ibid). The medical approach to “eating disorders” has not adequately taken this environment into consideration, and art therapists have generally not questioned this omission, with a few exceptions (Ball et al., 1996; Rust, 1987, 1992, 1994, 2000).

One aspect of this current research was to develop a methodology for including the clients’ perspective, and this provided the research with valuable feedback into the clients’ experience of art therapy within a feminist framework. From the clients’ point of view, the feminist framework itself was arguably the most important aspect of the
intervention. Both clients stated that aspects of this framework, such as being in a women-only space, having facilitators as positive role models, and learning and gaining support from other women, were extremely important elements of the art therapy intervention. The only area related to the feminist model which was not marked 10/10 by both women, was “the importance of learning from other women” which Barb marked 5/10, arguably because there was only one other women to learn from in the group.

Therefore it would seem fair to claim that the feminist approach was the most significant aspect of the art therapy intervention overall, more important than the use of art therapy, or the question of whether the treatment itself was effective. This is an extremely significant finding, and needs to be considered in future art therapy work with these clients.

The use of art work as research material

The second finding relates to the role of the art work in the consideration of research material. Traditionally, art work created in art therapy has been viewed through the lens of art therapists’ interpretations and has not frequently been presented in full as part of the case material. This has lead to a number of biases; in particular, the bias towards the art therapist’s view of what was significant, and in terms of what would be seen by a wider audience (Rose, 2001).
An important aspect of my approach to the art work that is demonstrated in this research is in the consideration of each image as part of the whole. In this case study I have included reproductions of all the images that were created by Anne and Barb in the ten week art therapy group. Anne and Barb gave permission for their art work to be photographed, and understood that it would be included in this study. Each art work can literally be seen in the context of the other art work that was created in previous and subsequent groups (Bourne, 2003, p. 5).

An example of the importance of this contextual approach, and the interaction between different images, is demonstrated when we compare two images by Anne: her image of the “Harpy” (figure 10) and “no” (figure 14). The first image, the “Harpy”, was extremely difficult for Anne to make; she said after the group she found it so difficult that she nearly walked out in despair. She was able to stay in the group by writing the word “OK” as a message to herself on the red paper, and drawing a small smiling creature above this word. She was therefore able to challenge her negative thoughts (about being unable to complete the activity) as soon as she became aware of them.

This image both contrasts with and illuminates the collage “no” which was created in the following week. The collage has the word “no” pasted above a cross-section image of a person’s head. This central image is surrounded by images of food and other “forbidden” things. Unlike the previous image, Anne found this collage easy to create. She stated that her most significant image that week was “the picture I had inside a person’s head, how it can give out so many negative messages”. Her comment can be seen, not only as a commentary on her eating issue, but also as a reflection on her feeling of “stuckness” the week before, when she was overwhelmed by negative messages. The fact that she

41 I have not included all the artwork created by myself and Sandra in the groups, as this was not the focus of the research. Art work created by the facilitators can be seen in figures 12, 13 and 16. This gives a general sense of our participation level. Future research into the artwork created by art therapists in art therapy groups could prove of great interest, as it is a source of a different kind of visual data than that produced by clients, and could provide an alternative ‘narrative’ to supplement the therapist’s voice.
had been able to challenge this negative thought about art-making, could serve as a “blueprint” for challenging negative thoughts about eating as well.

A further example of the interaction between images is shown in Anne’s image “Self portrait as an animal in a safe and an unsafe place” (figure 7). In this pastel drawing, Anne represented herself as a pig. She described this pig image as being taken from a poster she had on her toilet wall. This pig poster (figure 9) served as a ‘personification’ of her anorexia, in that it served as a reminder to herself not to eat. It seemed to have taken over the role of her parents in telling her how she should behave. After some group discussion about the role of this poster in Anne’s life, she decided to bring the poster to the group, stating that she did not want it in her house any longer, as she now recognised the negative message it was transmitting.

Barb’s images did not relate to each other so clearly, but there was often a similarity of themes noted in her artwork, such as: first, the use of cartoon images and cuddly toys; and second, various hints of sexual abuse (which was not disclosed) in the image of the man’s face in the mirror (which she associated with “looking back” at past events) (figure 4); the dirty male hands in the power collage (figure 6); the “phallic” candle (figure 15); her placing of the male figure on the side of “powerful”, and the female on the side of “powerless” (figure 6) and her feeling of being overwhelmed by the clay when she made the candle (figure 15). Each individual instance that was suggestive of abuse did not of itself seem highly indicative of abuse, but when taken as a whole, the impression could not be discounted. This “interpretation” of her images was not made to Barb but was noted by the facilitators, who became alert to the possibility that Barb may have been attempting to make a more direct disclosure.

The pig is the animal most closely associated with fat, greed and gluttony (Hillman & McLean, 1997), so it is often represented or alluded to by women with eating issues (see figure 1, “Leave me alone!!” by Bridget).
Another aspect of the art work in this research project is the interaction between the imagery, the participants, the group and their external worlds. This is demonstrated by considering issues of containment and non-containment of images within the group. One example previously discussed, is Anne’s decision to bring her “Pig poster” (figure 9) to the group, so that the group could contain the image and prevent it from further contaminating Anne’s thought process. This was an example of an external image becoming incorporated into the group container. Conversely, issues arose in relation to some imagery “leaking out” of the group container, and this produced negative reactions from both women. This involved, in Anne’s case, her “Egg capsule” (figures 18 and 19) being taken home and being seen by her parents, who ridiculed the activity. In Barb’s case, she decided to make her “Self-care poster” (figure 22) in two A4 size sheets, so she could hide it in ring binder and keep it private from her family, whom she found intrusive.

In psychodynamically oriented art therapy, the art work would have all remained contained within a folder and would not have left the group, “for the duration of the therapy” (Schaverien, 1995, p. 56). In some instances, in this research group, an alternative approach was taken, in order to increase interaction between images and participants (by suggesting an artwork was taken home, for example). Although the psychodynamic model was not adhered to in the art therapy group, it seemed clear that issues of containment were still applicable to this group.

The use of a group psychotherapy method for data collection in art therapy groups

One of the methodologies used for the collection of qualitative client feedback was the use of the questions about the “most significant image” (MSI) and the “most significant event” (MSE) previously used by Gilroy (1995), which derived from group psychotherapy (Bloch et al., 1985; Yalom, 1985). This has parallels in other forms of
social research known as the “critical incident method”. This proved to be an effective and easily administered method for the collection of clients’ comments on the image and the group they had just participated in. Some of the data that was generated included the following points in relation to the MSI:

- The process of art-making was the most significant aspect of the image.
- The image resonated with thoughts and feelings.
- The image resonated with the self.
- The individual related to another persons' art work.
- The image increased awareness of self and others.

And, in relation to the MSE:

- The art-making was the most significant event.
- Self-disclosure or catharsis.
- Self-understanding or insight.
- Interpersonal learning.

It will be noted that although the MSI and the MSE yield similar information, also the MSI gives us specific information about the art therapy process and how the artwork, in specific ways, enhances the therapeutic factors which are constant in any therapeutic group. Therefore it could be argued that the artwork improves the therapeutic capacity of the group.

The data was gained from only two participants. Similar research which is able to gain information from larger numbers of clients may provide evidence of additional therapeutic factors in art therapy.

The importance of asking clients for feedback on the art therapy process

The research demonstrates the validity of asking for client feedback on their experience of therapy in order to understand what is therapeutic and how it helps. Rather than
providing a radically different view of art therapy, this research found that the inclusion of clients’ perspectives actually strengthens the view of art therapy expressed by art therapists. The main benefit of this strategy, however, which is called “revolutionary” by Duncan, Miller and Sparks, is to improve the therapeutic alliance by viewing the clients’ perspective as equally valid (Duncan et al., 2004). Indeed their suggestion that we see the client as “the hero” of the therapeutic narrative actually places the client in the protagonist’s role and privileges the client’s position in relation to the therapist (Ibid).

*The benefits of art therapy as demonstrated in this research*

The research found that art therapy was viewed as effective by both the study participants. The responses to the MSI and MSE questions has already been discussed. When asked to comment specifically on the use of art therapy in the groups, Anne stated that: “It had a way of bringing out issues that would probably have been overlooked if it wasn’t art”. Barb said: “Art therapy seems to take the emphasis off focusing directly on my issues. It is an easier but still effective way of dealing with feelings”. Their statements highlight two aspects of art therapy which are thought of as useful by art therapists: access to unconscious or repressed material (Case et al., 1992, p. 51), and a safer, less direct way to explore feelings (Liebmann, 2004, p. 10).

*The combination of a case study approach with client feedback*

The research demonstrated that a case study approach could be enhanced by the addition of data collection from clients. The limitations of the case study approach was discussed in chapter six, in the consideration of research methodology (Rosal, 1989). The case study was still thought to have some merits. However, the combination of the case study
with client feedback results in a more well-rounded narrative of the art therapy experience, which does not just present information from the art therapist’s perspective.

The use of journals in combination with art therapy to improve client self-reflection

The use of journals was found to be beneficial to both participants. Journals aided their internal thought processes, and provided another step towards self-disclosure, especially in Anne’s case, who frequently rated self-disclosure via her journal as her “most significant event”. Journals proved to be a useful link between internal, non-verbal processes, and verbal participation in groups, and could usefully be incorporated into an art therapy program. They also provide an additional container for clients who, like Barb, are not ready to verbally participate in group.

10.2 Limitations of the research

Participation

The small number of participants is the most important issue to discuss in this category. Two participants is not an adequate number for a psychotherapy group, indeed as Foulkes (1964, p. 38) suggests, the ideal number for such a group is between five and ten, although he also says that group therapy occurs when “more than one patient is taking part at one and the same time” (Ibid). Other art therapy groups for women with eating issues had similar problems with participation levels (Fitzsimmons et al., 1996; Hinz et al., 1990). This could be partly due to the element of denial in the aetiology of eating issues, and the resulting difficulty clients have in voluntarily presenting themselves for treatment. It would appear further research is warranted to verify such a tentative linkage and conclusion.
The decision in the case of the research group, to proceed with the groups despite the low numbers, was an acknowledgment of the needs of the two participants who had put themselves forward. In other words, the therapeutic benefit for these women was thought to outweigh the needs of the research project to have a larger group sample. In fact, the two women generated enough art and other material for the group to be qualitatively evaluated, using a case study methodology. The researcher originally intended the focus to be on the group as a whole, rather than on two individuals. The low numbers meant that the focus of the research had to change.

If we had been using a group analytic model, the small numbers would have been more problematic, as the group dynamics may not have been fully activated. In a directive group, this was not such an issue. The active stance of the facilitators, which included participation and role-modelling, went some way to reduce these negative factors. The disadvantage was mainly that the participants did not benefit from input by a larger number of women, so that opportunities for interpersonal learning and socialisation were reduced. In terms of the research, the disadvantage was that although the participants rated the group highly in many areas, and indicated strong evidence in favour of a feminist approach to art therapy, ultimately this was the opinion and feedback of two women, and a larger number could be seen to carry more authority.

The issue of participation highlights the tension between research and therapeutic practice. However, the research project created an opportunity to examine a discrete piece of clinical work in far greater detail than usual practice allows. In this sense it was not about researching an “ideal” situation which bore little resemblance to real life. Rather, it was about exploring a piece of work in great detail and depth, and drawing conclusions from this which can inform future practice.
10.3 Implications for further research

The study has highlighted areas which would benefit from further research. Some of these are now briefly discussed.

*Use of outcome measures*

Since the clinical component of this study was completed, an easily administered outcome measure has been introduced (Duncan et al., 2004). This consists of two sets of four scaling questions, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) (Ibid) which, in combination, can be used to chart the progress of therapy. The ORS is used before the session, to indicate the client’s well-being in a number of areas (individually, interpersonally, socially and overall). This gives an overall score (out of 40) which when used over time indicates whether they are making progress in therapy. The SRS is used after the session, and indicates the client’s level of satisfaction with therapy.

Future art therapy research could investigate the effectiveness of art therapy (with individuals, groups, couples or families) using these simple and client focused outcome measures.

Alternatively, Nadija Corcos (2002) a solution focused art therapist in the UK, suggests the use of an image-based outcome measure, which uses the clients’ view of the future as the basis for this measure.
Use significant events questionnaires in further art therapy groups

Similarly, the questionnaires used in this research, about the most significant images and events, could be used to include qualitative material into investigations of art therapy groups. These may also be able to be adapted to individual art therapy.

Art work created by art therapists in art therapy groups.

Further research could pay attention to the art therapist’s role in group work, for example by investigating her artwork, her body image, or other aspects of her role, and the impact this has on group members and on herself. This may assist in illustrating the transference – counter transference dynamic with greater transparency, for example.

Spirituality

An issue that was not addressed in this research, which was identified as being unexplored in the art therapy literature (Hogan, 2001; Maclagan, 1998), was that of spirituality. Spiritual themes were not introduced, and neither did they arise spontaneously in our discussions, although, in my experience in training groups, they arise frequently. This is an area that would benefit from further research.

10.4 Summary of thesis

In the first chapter, I outlined the purpose of this study, and introduced some of the terminology used. This included an overview of the importance of addressing eating issues which are increasingly prevalent in Western societies, and a definition of
terminology used including current medical diagnostic terminology. The following chapter, chapter two, described the approaches commonly taken by art therapists in treating women with eating issues, in a broad survey of the literature from 1980 to 2005. The art therapy literature proved to be extensive but had some gaps, which were outlined in the following chapter. In addition, chapter three provided a critique of the existing art therapy literature. Chapter four introduced some alternative, non-art therapy approaches to the treatment of eating issues, informed largely by feminist therapy and other ‘new order’ psychotherapies.

Chapter five laid the foundation of a feminist informed, art therapy methodology for the treatment of eating issues. This involved exploring the lack of a feminist perspective in art therapy literature, with a few exceptions. These exceptions were described, particularly those which included feminist art therapy approaches to eating issues. Chapter six described the design and methodology for exploring feminist informed art therapy practice in a specific community setting, using the format of a dual case study. The methodologies selected were informed by group psychotherapy research into therapeutic factors, art therapy case study methodologies, and qualitative and phenomenological approaches to research. Chapter seven consisted of a narrative of the art therapy intervention that was implemented in this dual case study. In chapter eight the results of the study were presented, and in chapter nine the results were discussed, particularly with reference to the gaps in the literature which were identified in chapter three, and in relation to the therapeutic factors as identified in group psychotherapy research.

In this thesis I hope to have shown how a feminist approach may be adopted into an art therapy project for women with eating issues, both from a theoretical and from a practical perspective, and how such a project may be evaluated. Despite the small scale of this project, I hope it will inspire other art therapists, in terms of the following: - using alternative frameworks; including research strategies in their clinical work; and providing
the art therapy literature with much needed evidence for the efficacy of this unique way of working with clients.
Appendix A: Pre, Mid and Post Group Questionnaires

Pre-group Questionnaire

1. How would you describe your eating issue?
2. How is it (the eating issue) impacting on your life now?
3. How long have you had this eating issue?
4. Have you had/are you currently having any treatment (medical or otherwise) for this eating issue?
5. If you woke up one morning and discovered that a miracle had happened and you no longer had this eating issue, what would be better?
6. How would you describe your body now? Pick three words only
7. How comfortable do you feel in your body now? Please mark an ‘x’ on the line:

| 1 | extremely comfortable | 10 | not at all comfortable |

8. Where in your body do you feel ok? (use diagram A)

![Diagram A](image)

9. Where in your body do you not feel ok? (use diagram B)
10. How do you feel about using art in these groups?
11. What do you specifically hope to gain from these groups?

Thank you for completing this questionnaire
© Claire Edwards 2000
Mid Group Questionnaire

1. How would you describe your eating issue?
2. How is it (the eating issue) impacting on your life now?
3. How would you describe your body now? Pick three words only
4. How comfortable do you feel in your body now? Please mark an ‘x’ on the line:

1 10
extremely comfortable not at all comfortable

5. Where in your body do you feel ok? (use diagram A)

6. Where in your body do you not feel ok? (use diagram B)
7. What do you specifically hope to gain from these groups?
8. Are these groups meeting your needs? Yes/No Give details.
9. How could the groups be improved to meet your needs better?
10. What could the workers do to improve their role in the groups?

Thank you for completing this questionnaire
© Claire Edwards 2000
Post Group Questionnaire

1. How would you describe your eating issue?
2. How is it (the eating issue) impacting on your life now?
3. How would you describe your body now? Pick three words only
4. How comfortable do you feel in your body now? Please mark an ‘x’ on the line:

2     10
extremely comfortable not at all comfortable

5. Where in your body do you feel ok? (use diagram A)

6. Where in your body do you not feel ok? (use diagram B)

7. How did you feel about using art in these groups?
8. What did you specifically hope to gain from these groups?
9. Did this occur?
10. Did these groups meet your needs? Give details.
11. How could the groups have been improved to meet your needs better?
12. How could the workers have improved their roles in the groups?
13. Has art therapy been a factor in your participation in these groups? How?
14. Is there one image, or series of images, which sums up for you your experience of these groups? If not, could you create one? (time could be set aside for this)
15. How important was it for you to:

a) Be in an all-women’s group? Please mark an ‘x’ on the line:

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<tr>
<td>extremely important</td>
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b) To have workers as positive role models? Please mark an ‘x’ on the line:

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<td>extremely important</td>
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c) To learn from other women in the groups? Please mark an ‘x’ on the line:

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d) To gain support from other women in the groups? Please mark an ‘x’ on the line:

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<tr>
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e) To use art in the groups? Please mark an ‘x’ on the line:

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<tr>
<td>extremely important</td>
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16. Do you have any further comments or questions about the eating issues groups?

17. Do you need to come back after the groups for a final debrief?

Thank you very much for your participation in the research process.
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Appendix B: Weekly schedule for eating issues group

The following is a brief outline of the group sessions.

**Week One: Introductory Session 1.** This session will look at our expectations of these groups, and thoughts about how we would like to be treated in order to feel safe and comfortable. We will look at basic information about the group process, and about using art therapy. We will play some introductory and interactive ‘games’ using drawing materials.

**Week Two: Introductory Session 2.** Some new women may join the group at this stage, so the guidelines generated in week one will be revisited. The session will involve several quick collage activities using photos cut from magazines, and we will also have the opportunity to ‘play’ with other art media. Again the session will be introductory, so the focus will be on “getting to know each other”.

**Week Three: Representation of Self to Group using drawing activity.** In this group we will be looking at ourselves in relation to our environment, and in particular where we feel safe, and where we feel uncertain. The drawing activity will involve using drawing to look at this issue, and also to generate some ideas about our strengths and strategies for building on them.

**Week Four: Understanding negative beliefs, and challenging them.** This session will explore messages we may have received about ourselves, including our body-image, from families, friends and the media. We will make a ‘harpy’, which is a physical representation of our “inner critic”, in order to externalise this voice and begin to challenge it. We will use cardboard and collage materials to make the harpy.

**Week Five: Representation of Eating Issue in a visual form.** We will have the opportunity to make an image, which represents our eating issue, in any form that we choose. This can be abstract, symbolic or representational. It could be about a single incident, a feeling, a relationship, or an overall statement. This will be an open media session, so clay, paints, and dry media will be available. This activity will help us to focus on our eating issue in a safe space. It can also help us to start to explore how the eating issue may be serving a particular purpose in our lives at this moment in time.

**Week Six: Representation of Self using 3D media, and/or Treasure Map.** We can often lose sight of different aspects of ourselves, and the self-box activity helps us to look at the different parts, using collage materials on cardboard boxes. The “Treasure Map” activity identifies our wants and needs, and invites us to make an assertive statement.
about these, as a preliminary to making sure these wants and needs are met. A photo of us is needed for this activity.

**Week Seven: Family Groups using clay or collage.** This activity explores our “family of origin” and helps us to look at the dynamics we may still be enacting in our current lives. Some of these dynamics may be helpful and others unhelpful. We will have a choice of either clay or collage to represent our families.

**Week Eight: Body Outline Drawing using any media.** Making a life size drawing of ourselves using any media. We can use the body outline to represent our physical body, or our emotions, our history, our interactions with others, in fact any aspects of ourselves we would like to portray using a variety of media.

**Week Nine: Closure Session 1, “Life Map”.** Group activity. This will involve a group drawing or painting to represent, either as individuals or as a group, where we have come from, where we are now, and where we are heading. This can be abstract, symbolic or representational. (Alternatively, the group could decide on its preferred theme).

**Week Ten: Closure Session 2, “Group Gifts”.** What was gained, what was difficult, giving symbolic ‘gifts’ to other group members. We will review the series of groups and give feedback to the facilitators. We will explore ways to celebrate endings.

**Format of Each Session**

The sessions will run for two hours, from 12.30 to 2.30 p.m., on Wednesdays from 1st March 2000. Each session will start with a brief “check-in” activity (15 mins). This will generally be followed by the main art activity (30 mins). The second hour of the group will be a time for sharing and processing the images (artwork), and other issues arising from the session (55 mins). There will be a brief “finishing activity” at the close of each group (5 mins). These times are approximate only, and can be changed if necessary, to suit the needs of individuals and/or the group.

The first session will have a slightly different structure, to allow time for the group to set some boundaries and guidelines, and for introductory information to be shared.
Appendix C: Hopes and fears for eating issues group

**Hopes and fears for eating issues group**

**Hopes**

- To be more in control of my thoughts and feelings around eating
- To feel better about myself
- To not care what others think
- To feel like I am not alone
- To feel more understood (by others)
- To understand my eating issue
- To form connections with other women with eating issues
- To realise what I need to do to change my eating issue

**Fears**

- Thinking about my eating issue more than before
- Affecting my behaviour around eating negatively
- To worry about what people in the group will think of me
- Confronting what is behind my eating issue
- Talking about my eating issue, because I don’t usually talk about it
- Other people may find out about my eating issue
- No longer having an eating issue (fear of change)
- Fear of using art
Appendix D: Group guidelines, Weekly questionnaire, Closure activity

**Group Guidelines: How This Group Will Feel Safe**

- Non-judgmental
- Confidential
- Respect for self and others
- Be honest with yourself and others
- Speak up
- Try to understand other people’s views and/or feelings
- Support others
- One person speaking at a time
- Acceptance and accountability/responsibility (i.e. if I am upset I will try not to run out of the group)
- Listen to others
- No butting in
- Don’t put people down

**Weekly Questionnaire completed after each group**

1. What was for you the most significant image/artwork in the group? (Give details)
2. What was for you personally the most significant event in the group this week? (Give details)

**Closure activity - Eating Issues Group**

1. Something you have gained from the ten week group
2. A message for the other group members
3. Something that is unhelpful that you are able to let go of
4. Something you can continue to work on
5. A wish for the future
Appendix E: Barb’s journal

Barb kept a journal throughout the period of the art therapy groups, and she sent me a copy of some of her entries to include in this project.

8/3/00 (After week 2’s group)
I brought up a few scary things about my eating issue today that I’ve never admitted to anyone, including myself. Flicking through the magazine pages the bottles seemed to call out to me. They reminded me of medicine bottles and how I sometimes take enough tablets to make myself feel sick, and to not feel hungry. To get away with not eating for longer. I feel a slight release of pressure has been lifted from me, and while I know that just admitting the issue won’t make it vanish, at least I am more aware of it now. What I really need is to feel OK about me, and to not care about what anyone says or thinks. That’s the difficult part.

26/3/00 (after week 4 “Harpies”)
I watched Bronte’s Story (2000) tonight. A true story about a young woman’s battle with anorexia. Although I don’t have anorexia, I could relate to most of the feelings she spoke about. The demon (harpy) which never leaves and how difficult it is just to keep going. The pain and torment is so horrible that you’d rather die to have some peace. To have your life back to ‘normal’ again.

12/4/00 (after week 7 Discussion on self-care)
How can I think of ways to nurture myself when I feel that I don’t deserve to be nurtured. It is so much easier to flow along and agree with the harpy inside, than it is to fight anymore. Besides, I don’t have any energy left.

29/4/00
When I look back over my life up until now, I think of the times I pushed myself as far as I could go, to try and succeed so as to earn respect, satisfaction and to feel loved not just from myself, but more often from others. Of course it never worked, if anything it became worse for now there is even greater pressure on me to live up to the higher expectations I was once able to fulfill.

I sit here full of anger towards myself while family members and other close acquaintances remind me constantly of where I used to be and how much of a disappointment I am now. So everyday I hate myself that little bit more.

I have tried to tell myself that I really do deserve love, satisfaction, success and respect but it doesn’t seem to matter how often I tell myself this my heart doesn’t believe it. Maybe that’s because the people closest to me, my family, don’t believe it. Does this mean I am a bad person?
Barb’s journal commentary clearly displays the negative self-talk and suicidal feelings she was experiencing during the group process. There is a strong sense of her isolation within the family and feeling overwhelmed by both her disappointment and their’s at her current situation. At first glance one might question whether she got anything of value out of the groups. However, she also made the following statement, in a ‘message to other group members’, from the last group’s activity.

I am glad to have been part to this group. Watching, listening and sharing (though extremely difficult at times), had been rewarding. Emotionally, mentally and spiritually I believe we have all grown. Please remember our time together and use them as your strength when things become challenging. May you continue to grow.

Barb also writes in the note enclosed with these messages: “Sorry for being a pain in group!”
Appendix F: Poems

This appendix consists of a poem by Barb, as a response to the group session on the “Harpy”, and a poem by Saskia. The latter was used as a group resource in the form of a handout.

Camouflage by Barb

My thoughts become muddled.
Distracted.
The voice so criticising and insistent.
I spin around quickly,
Only to find I am alone.

The air has become cold.
I turn and walk outside.
The voice is still beside me, almost hissing now.
Like a snake about to strike.

I block my ears,
I can’t bear to listen.
Yet the words continue to pierce my flesh,
So painful.
So true.

Out here the other passers-by keep walking,
Unaware of my personal torment.
My silent unanswered prayers.
Please stop the voice.
Please save me…
…from myself
Healing by Saskia

In order to be healthy
I need to say goodbye
You can only hurt me
So I should leave you standing by
Happiness can only come
When I learn to let you go
But I just can’t seem to do it
Although you can hurt me so
I can not close the door
I can not turn away
I still want your rewards
I still want you to stay
I want to be happy
…but I want to be thin
I want to be healthy
…but I want to fit in
I am so confused
I don’t know what to feel
I need to find the answers
So I can start to heal
I know what I must do
I need to turn away
And I’ll promise I’ll try harder tomorrow
I just couldn’t do it today.
Appendix G: Recommendations for (art) therapists

The approach described... challenges the therapist to step out of the role of a silent expert and to struggle actively with the patient... it challenges therapists to be clear about who they are and how they relate to others. It encourages therapists to be aware of their own struggles with shape and weight... It demands an understanding of the cultural context in which an eating disordered patient’s struggle takes place, as well as the provision of a relationship where the patient can clearly experience herself as having an impact on others. (Kearney-Cooke, 1991, p. 316)

Be aware of the increasing diversity of women’s roles, and of the reality of the client’s situation; offer encouragement; promote independence (including from the therapist); offer support and belief in her ability; recognise the need for social activism. 43 (Brodsky, 1973, p. 27)

Perhaps the strongest message... is that women are capable of using other women as models. ..The acceptance of more varied roles and personality traits in women will help to integrate a larger portion of women into the “mentally healthy” categories. (Brodsky, 1973, p. 28)

Work in a non-medical/behavioural model; facilitators are not experts; co-work across disciplines; awareness of own feelings about food; regular evaluation and supervision; avoid medical labels such as ‘anorexia’; confidentiality, self-referral service; range of services to meet differing levels of need. (Ball et al., 1996)

- Being likeable, friendly and responsive.
- Carefully monitoring the client’s reaction to comments, explanations, interpretations, questions, and suggestions.
- Being flexible: doing whatever it takes to engage the client.
- Validating the client. (Duncan et al., 2004, p. 65)

43 Social activism is defined as activities aimed at promoting positive social change (Brodsky, 1973, p. 27)
Appendix H: Art therapy in fiction

The following three excerpts are fictional accounts of the client’s perspective of art therapy (or, in the third example, creative writing) used in treatment for eating issues.

1. Body outline drawing

In the following excerpt from The passion of Alice by Stephanie Grant (1996), the narrator Alice is an inpatient with anorexia. She goes to art therapy, where the patients trace around each other on large sheets of paper and then, over several weeks, make paintings or collages based on these body outlines:

   After days of inactivity, I had decided to render my body, as accurately as possible, without its skin. Cass had ruined my first impulse – stacks of nimbus, cirrus, and cumulus clouds. I had just sketched the outline of my first cloud, a filmy cirrus in place of the features of my face, when Cass felt compelled to mention a former student who had done very successful clouds. She said it like a simple point of information, as though it wouldn’t bother me, not being unique. I was stymied for days. Then I had what Cass called a “breakthrough”. I asked to borrow an anatomy book from Medical. She said she preferred imagination to accuracy. I concentrated on the cardiovascular system. If I closed my eyes, I could still see the graphs and charts from cardiac care, the prominent pink heart and miles of muscular red wire. I asked for paints and brushes. (Grant, 1996, p. 176)

2. Clay

This novel, by Jenefer Shute, (1992) Life-Size describes an admission into hospital of a woman with anorexia: in particular her resistance to treatment; and her eventual turnaround through a strong relationship with her nurse. Josie’s resistance to all treatment includes art therapy, which is regarded with suspicion and disdain. “I don’t need “art therapy”” I tell her” (p. 38). The ‘art therapist’, as Josie sceptically describes her, is portrayed as an object of disgust, partly to do with her large size, as is the clay she
offers Josie to play with (p. 40). The difficult relationship between Josie and her mother is re-enacted in her relationship with the ‘art therapist’. Despite her disgust, Josie does interact with the clay, and with the ‘art therapist’, although minimally at first. Initially, Josie fears she will be forced to touch the clay, in a parallel of the fear of being forced to eat “for your own good”. She is able to identify strong emotions in reaction to using the clay, too:

“It’s an abstraction”, I reply, wanting to cry. I pick up the ball of clay – it’s warmer and grittier than I expected – and smash it down on my person. Then I hand her the clay and say, “Thanks, that’s enough now”. (p. 41).

In another later chapter/session, Josie’s response to the ‘art therapist’ bringing her clay is to say “Take that crap away”, again as if the clay were food. When Josie does pick up the clay, she is again overcome with strong sensations:

A powerful urge to cram the whole thing into my mouth seizes me: what it most reminds me of is cookie dough...Using the edge of my hand like a rolling pin, I flatten out the dough on the tray and then mark out four small circles with my forefinger. She’s watching me proudly now: what a good girl. With my fingernail, I pare each clay disc loose and line them all up, painstakingly indenting their surfaces until they’re rough and irregular.

“What are those?” she asks me.

“Can’t you see?” I respond. “You’re supposed to be the artiste.”

“Buttons?”

“Buttons? Are you out of your mind? These are cookies.”

“But why so tiny?”

Why do you think?” (p. 121)

The challenge is also to us, as the reader, to understand the meaning of Josie’s art work. This episode leads to more memories of binge-eating, when she would end up in a semi-comatose stupor on her bed; Josie says “Why resume consciousness at all, when inhabiting a body is such hard work?” (p. 124).
3. Writing

*Cardboard: The strength thereof and other related matters* is an autobiographical novel by Fiona Place (1989) about one woman’s experience of anorexia and the treatment she receives in hospital in Sydney in the 1980’s. This treatment includes a behavioural program based on rewards for weight gains, and individual therapy sessions with a psychoanalytic psychotherapist, and with a psychiatric registrar.

Place’s protagonist, Lucy, describes anorexia as being ‘first and foremost a language problem’ (p. 97). This is how she experiences her non-verbal internal process:

> Now longing type feelings changed to anger, without ever coming close to owning words…I guess I was trapped by waves from within, without a dictionary, without any sort of vocabulary. (p. 96)

One of Lucy’s strategies whilst in the revolving door syndrome of frequent hospital admissions and discharges, is to start to write in her notebook about her transition “from fragility to hostility”, a transition which she recognises as being an aspect of her anorexia developing:

> I grabbed hold of my pen and tied to plot trace its course in my faithful notebook. I knew I had been fragile...but that suddenly the Panic had pounded on in. As it always did. And resulted in the appearance of Chaos. Chaos which drip melted me all over the sheepskin. And forced me to write myself back into existence. (p. 85)

As in anorexia, language is also an issue in psychiatry, according to Lucy, who articulates its overarching power over its subjects:

> The medical profession, under the guise of uniforming language for the purpose of clarity, adopts a language of clinical description. The clinical discourse…is a language imbued with middle class ideology and its design is neither merely to prescribe the most appropriate treatment nor to keep patients from understanding their condition fully, and thereby keep the patient dependent on the physician for her/his expertise. Their desire to influence, I would suggest, extends far further than that. And to cover their desire they use a language which denies sub-
texts…and it would seem to me that any language that denies sub-texts must be diminished in its capacity to effectively treat illness (p. 97)

Lucy describes her language/anorexia problem as being in part the inability to “decode subtexts” in normal human discourse, to take what is said literally and to miss the nuances behind what is said. This is similar in some ways to the narrative therapy approach, which encourages people to reconstruct their own narratives of what has occurred in their lives. Narrative therapy has been cited as an effective approach with eating issues and the reader is referred elsewhere in this review for a description of this.

It was the relationship she formed with the registrar which Lucy describes as being the most significant, with the emphasis being placed upon the need for honest communication and genuine caring on the part of the doctor. This in spite of his unorthodox approach, of teasing and flirting with Lucy, and projecting his sexual feelings onto her at every opportunity, which borders on harassment but never quite teeters right over the edge of professional boundaries.

The ‘cardboard’ in the title refers to the list of doctor’s appointments given to in-patients which confers upon them the status of knowing when the doctor will see them, so not having to hang around waiting for them all day.

Since her recovery, Place has worked as writer-in-residence in psychiatric hospitals, and has been a strong advocate for the need for creative outlets for psychiatric patients.
Bibliography

I Just Want to Melt Away


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