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An exploration of ego development and the suppression of anger in persons
with borderline personality disorder as seen in
art therapy: A case study

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ABSTRACT

An exploration of ego development and the suppression of anger in persons
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This paper explores the process and efficacy of art therapy treatment with a person

diagnosed with borderline personality disorder (BPD), who had attempted suicide.

Personality disorders are separated from major mental disorders in both severity

and classification. They are described as behaviours or traits that are characteristic of

recent and long-term impaired social or occupational functioning which cause subjective

distress. Clients with the diagnoses of BPD, those traditionally labelled as 'hard to

handle' and 'unresponsive to therapy', are included in the Cluster B category of

personality disorders which also includes antisocial, histrionic and narcissistic personality

disorders. There are a number of typical criteria which appear to be due to a combination

of biopsychosocial factors, and include, but are not limited to, affective instability,

inappropriate intense anger and poor ego boundaries.

The hypothesis of this paper is that some people are likely to suppress (act-in)

rather than act-out their anger; the affective instability presents as suicidal intent. It is

further hypothesised that the use of art as a transitional and holding space can contribute

to ego development and subsequent emotion regulation. In this case, eight months of art

therapy was the primary treatment modality, and there have been indications of changes

in this person's lifestyle and coping behaviours.

ACKNOWLEDGEMENTS

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INTRODUCTION

Statement of the Case Study

The client who has participated in this case study has the Axis II diagnosis of borderline personality disorder (BPD) and has a long history of suicide attempts. One of her first verbalized expression of an emotion in an art therapy session was anger, although there was no affective component attached to this vocalization. This paper explores the connection between mu client's displays of emotion without affect (in this case. anger) and her BPD diagnosis. I reflect on our art therapy sessions and their relationship to her diagnosis. Furthermore, I illustrate the changes I observed in her behaviour throughout the experience of art therapy.

In order to engage in such an exploration, this paper travels through several venues. To begin with, it consists of literature reviews of the etiology and characteristics of borderline personality disorder, ego development, anger suppression (including associations to BPD), and art therapy. These reviews are then linked to and examined through the art therapy process and the experience of the client, expanding on personal theories concerning the above factors, links, connections and comparisons of the findings of this study.

In working with clients diagnosed with BPD, I have observed that the diagnostic criteria of "affective instability" and "inappropriate intense anger" (American Psychiatric Association, 1994) manifest in various ways in different people. On the one hand, there are those who ineffectively rage at the world, while on the other. there are those who turn that rage in on themselves. This paper connects BPD to the stages of ego development.

Such a link appears to be supported in BPD literature. In turn, through a case study, this work engages in a thorough exploration in the area of ego development and its implications for suppressed anger in a person diagnosed with. This research and inquiry also examines the role of art therapy as a facilitating framework and holding environment.

Statement of the Research Question

What, if any, is the connection between ego development, suppressed anger and BPD? Can, and if so, how, does art therapy contribute to a therapeutic environment for people with BPD? Subsidiary questions that are explored are: How is suppressed anger expressed in an art therapy session? Can symbolic experimentation assist people with poor ego functioning/boundary diffusion to own and integrate their anger? How does the client manifest boundaries in art and what is the nature of these boundaries?

Research Design and Method

This research paper uses the model of a case study as its basis. An initial literature review of the areas of research - ego development, anger suppression, borderline personality disorder, and the use of art therapy as a therapeutic modality gives way to the actual experience of the art therapy sessions. A discussion and synthesis of the client's and therapist's findings are given, along with suggestions for possible future research in this area.

CHAPTER 1

LITERATURE REVIEW

Ego Development

Sigmund Freud divided what he called the person's psychic apparatus into the id, ego, and superego, a construct that he believed portrayed the three structural components of one's personality. The first component, the id, was the source of acquired primitive desires that were driven by life and death instincts, drives that influenced behavior and were available from birth. Guided by the pleasure principle, and using primary process thinking, one drew on such drives to gratify basic needs by maximizing pleasure and reducing tension without concern for morality or reality. The second component, the ego, was as a developing part of the id which one used to control the id's drives and impulses to conform more closely to the demands of society, as one learned to wait for gratification. Freud's theory was that ego development was governed by the reality principle and employed secondary-process thinking (reason and logic). The ego balanced the demands of the real world with the energies of the id and therefore must be strong. Freud stressed that the ego should not be weakened by drugs, alcohol, serious emotional stress, etc. The third component, the superego, developed later in life and was basically seen as what we call 'conscience'. According to Freud's belief, these three components were often in conflict with each other because of their different goals and methods. Whenever the ego was overwhelmed by either or both the id or superego, internal conflict (anxiety) and psychological symptoms ensued, which if unresolved, lead to mental disorder. (Freud, 1961).

Freud's daughter, Anna, (Freud, 1965, 1970) took up the work on ego development, stating that organization, defense and structuralization were inherent in the ego. She explained more fully how the ego defends itself when reason and intellect cannot reduce the anxiety or tension caused by the competing demands of the id and superego. Both Freuds believed that these protective devices operated outside of our conscious awareness, and even, at times, our control. Consequently, when the ego functions were inadequate to meet the needs of a situation, one could come to depend on the ego defenses. Therefore, one could avoid dealing directly with the cause of the anxiety. However, this dependence upon the ego defenses would lead to emotional disorder, if further decompensation occurs, thereby preventing the ego from healthy functioning.

Anna Freud described the ego functions as developing through a back and forth, trial and error pattern. These functions worked to give the individual control over motility; the ability to develop reality testing; to integrate and adapt to society through frustration tolerance and impulse control; to learn speech, bowel and bladder control; and to master anxiety (Freud, 1970). She believed that these advances in ego development were required for the capacity to work and that they were developed by the mother's stimulation of specific interests. By that, it is believed, Freud meant that the infant would develop that which brought the mother's love and approval and neglect other behaviors where such approval was withheld or not given. As the child developed, so did the ego strength. When tensions and drives were in too strong a conflict, defense mechanisms would be mobilized to protect the beleaguered ego, and, if used in moderation, they

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would be added to its arsenal. Otherwise, the overuse of the defenses weakened the ego, thereby leading to the possible development of personality disorders.

Although time has not been kind to Sigmund Freud's theories of personality development through psychosexual drives, libidinal stages and unconscious sexual feelings, the concept of the ego led to a large field of study and the term is still used today, albeit in a somewhat modified manner. Melanie Klein (Segal, 1974), building on Freud's concepts, developed the theory of unconscious fantasy based on the role of symbol formation and ego development in children. Segal, in describing Klein's theories stated,

> Phantasy-forming is a function of the ego. The view of phantasy as a mental expression of instincts through the medium of the ego assumes a higher degree of ego-organization than is usually postulated by Freud. It assumes that the ego from birth is capable of forming, and indeed is driven by instincts and anxiety to form primitive object-relationships in phantasy and reality. (p.13-14)

Objects, in this sense, are meant to describe anything, including people, that the infant comes to understand as separate from the self. She went on to explain how Klein furthered Freud's introjected object ego description,

> To begin with, part objects are introjected.... then whole objects.... The earlier the introjection, the more fantastic are the objects introjected and the more distorted by what has been projected into them. As development proceeds, the reality-sense operates more fully, the internal objects approximate more closely to real people in the external world.... Thus, a complex internal world is built up. The structure

of the personality is largely determined by the more permanent of the phantasies which the ego has about itself and the objects that it contains. (p.19-20).

As the child interacted with the outer world, he engaged in reality testing of his fantasy belief system, using thought to modify fantasy to accommodate reality, thereby both using and contributing to a higher degree of ego organization.

As stated by Ausubel (1952, 1996), over time the concept of the ego has become more fully merged with the concept of self, "...because of the manifest impossibility of explaining the major portion of man's behavior without assuming some reference to the self." (1952, p.12). Ausubel devised a diagram to show the relationships between the body, self, ego and personality, which can be paraphrased as follows: the body (visual image of one's appearance in space) + self experiences = the self. This self + all self-identity = the ego. The ego + skills, habits, memories, etc. = personality. Like Anna Freud, he believed that the stages of maturation are determined mostly by parental attitudes, "...that it is in the small and subtle aspects of these relationships that the security of the child develops" (p.32). Ausubel stated that ego development is a continuous biosocial shaping process that is influenced by environmental forces on genetic determinants, which are further impinged upon by "psychological capacities for perceiving self and environment" (p.46). He went on to state that the ego, "can be nothing more or less than an organization of values, attitudes and aspirations related to an abstraction of self." (p.46).

In keeping with the idea of the ego as a construct, Landis (1970) was concerned with ego boundaries as a concept focusing specifically on the separation between the ego

and the external world. In this case, the ego refered, "to the total awareness a person has of the subjective contents of his own existence" (p. 2), including values, goals, emotions, moods, attitudes, experiences of relationships, possessions, body, past, present and future. This awareness did not include consciousness of the ego boundaries, as a person was not ordinarily aware of this demarcation. But, it is necessary to have some separation from the non-ego in order to have an understanding of ego.

> The nature of a person's ego boundaries is, in large measure, a function of his position on this bipolar continuum [between isolation and fusion].... The conflicting needs for relatedness and for separation, for belonging and for individuation, are both necessary for a coherent sense of one's self.... Man is thus faced in his development with the task of achieving relatedness while developing himself as a unique entity. In boundary terms this means, optimally, that the demarcation of ego from nonego should be neither too permeable nor too impermeable. The former state leads to fragmentation or to symbiosis, and the latter to isolation; both involve a loss of selfhood (p.2-3).

This blurring of the ego/self definitions has continued with theorists such as Kohut's (1971) and Masterson's (1988) theories on the development of the "real-self" and the need for stable ego boundaries for successful separation and individuation. Masterson noted that,

> when analysts turned their attention to patients with psychoses and character disorders, the sense of comfort disappeared. These patients' development was arrested... at the preoedipal level and, therefore, their deep difficulties were

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predominantly with the functioning of the self. The lack of a fully developed

concept of the self, which had not previously been an obstacle, now became one.

(p.12).

He placed major emphasis on the link between the separation and individuation process

and the growth and maturation of the self and object representations. In short, he

believed that the psychological development of the self was attendant on working through

specific ego defenses.

Greenspan (1989) wrote on the development of the ego from a biological as well

as a psychological and clinical perspective. He theorized that depressive BPD

symptomatology was used as a defense against the fear of aggression and looked at how

specific developmental stages supported specific interventions.

In this paper, the term ego development is used to describe the evolution and

maturation of the individual's personality and the conscious awareness one has of their

personal existence. Ego. although relatively interchangeable with the term self. will refer

to development within the framework of biological (genetic). psychological (psychic) and

social (environment) influences. Ego psychologists agree that the ego (the core self) has

tasks that have to be performed to maintain personal integrity and cope with the outside

world. I believe that these tasks begin at conception and continue throughout life,

although the majority are learned in early childhood.

The following is a recapitulation of what were regarded by Kaplan, Sadock &

Grebb (1994) as fundamental ego functions:

Control and regulation of instinctual drives: one must develop the capacity to

delay or postpone drive discharge, allow the ego to mediate between the id and the

outside world, thereby becoming socialized, including language acquisition, and

secondary process/logical thinking.

Judgement: develop the ability to anticipate the consequences of one's actions,

including the ability to think logically and assess how one's contemplated behavior may

affect others.

Relation to reality: there are three components - *sense of reality* (bodily sensation

awareness, the ability to distinguish what is inside from what is outside the body); *reality*

testing (the ability to distinguish internal fantasy from external reality); and *adaptation to*

reality (the ability to develop effective responses to changing circumstances on the basis

of previous experience with reality).

Object relationships: The capacity to form mutually satisfying relationships,

which is dependent upon the ability to integrate positive and negative aspects of others

and oneself and maintain an internal sense of others, even in their absence.

Synthetic function of the ego: The ability to integrate diverse elements into

consistent and enduring representations, which also involves organizing, coordinating and

generalizing or simplifying large amounts of data.

Primary autonomous ego functions: The ability to develop functions of

perception, learning, intelligence, intuition, language, thinking, comprehension and

motility. These are present in rudimentary form at birth and develop in a reasonably

supportive environment.

Secondary autonomous ego functions: These are functions that may arise in the

service of defense against drives, but subsequently become independent of them (e.g., caretaking).

In addition, the defense mechanisms developed at the various stages of personal growth are used to protect the self from perceived harm. Signal anxiety (Freud, 1961) mobilizes the ego's resources which, depending on one's developmental level, will allow one to deal with distressing stimuli. Mature defenses are considered normal and healthy adaptive mechanisms of adult life, while the overuse of narcissistic, immature, and neurotic defenses is seen as maladaptive behaviour. The consistent use of specific defense mechanisms within an environment is perceived as indicative of personality character. Kaplan, Sadock & Grebb (1994) stated that,

> The extent to which the ego has developed a capacity to tolerate the delay of
> impulse discharge and to neutralize instinctual energy determines the degree to
> which such character traits emerge in later life. The exaggerated development of
> certain character traits at the expense of others may lead to personality disorders
> or produce a vulnerability or predisposition to the psychoses. (p.252)

The following literature review on BPD shows that this disorder is seen as related to maladaptive ego defenses, poor ego boundaries and inadequate environmental support.

Borderline Personality Disorder

Personality is the relatively consistent way a person feels and behaves in a wide range of situations, allowing for adaptation or adjustment within specific situations. The four personality temperaments defined by the ancient Greeks - choleric, sanguine,

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phlegmatic and melancholic - were the early definitions of personality types as we know them today. In contrast, personality *disorders* consist of normal characteristics and traits that have developed in a way that no longer contribute to healthy functioning in the world. According to Andreasen and Black (1995), these behaviors or traits that are characteristic of a person's recent and long-term functioning must cause either serious impairment in social or occupational functioning or subjective distress over long-term, rather than short-term, functioning in order for them to be considered disorders. Freud believed that the development of a personality type was due to specific fixations at certain developmental stages, which accounts for the DSM-IV classifications of personality disorders corresponding to these stages. However, there is little evidence of fixations developing into specific personality patterns. More recently, both genetic factors and neurobiological models appear to help explain some of the etiology of personality disorders.

Personality disorders have been classified in the DSM-IV into three clusters, each with phenomenologically similar characteristics, or whose criteria tend to overlap. Cluster A consists of the odd, eccentric disorders; Cluster B includes the dramatic or emotional disorders; and Cluster C contains the anxious disorders. The subject of this review, borderline personality disorder (BPD), falls into the Cluster B category. There has been a large amount of theorizing and extensive writing on this topic, and there has been much controversy over just what it is that constitutes BPD. Further, until recently, much of the writing has been based on subjective clinical experience rather than on statistical testing.

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The psychiatric use of the term "Border Line" was first introduced by Adolf Stern (1938). He described recognizable characteristics which included: "narcissism, psychic bleeding, inordinate hypersensitivity, psychic rigidity, negative therapeutic reactions, feelings of inferiority, masochism, wound licking, somatic anxiety, projection, and difficulties in reality testing". He considered such characteristics borderline to schizophrenia or hysteria. BPD has also at times been defined as bordering between psychosis and neurosis, presenting with cognitive function problems similar to those found in schizophrenia (Paris, 2000). The term "borderline", referring to a separate entity, was popularized by Robert Knight in 1953. He was the first psychoanalyst to clearly separate the borderline condition from the realm of schizophrenia. Gunderson (1977) showed that BPD could be distinguished from other major mental disorders and other personality disorders. This led to the inclusion of borderline personality disorder as a separate entity in the *DSM-III* (American Psychiatric Association) in 1980. The inclusion of this disorder finally gave it legitimacy and led to an increase in interest. The definition of BPD has been refined over the years, retaining some of the original characteristics, but excluding or including others. Stone suggested that there are three borderline subtypes: one related to schizophrenia, a second related to affective disorder, and a third related to organic brain disorder, although today the syndrome is mostly located on the affective disorders continuum (Linehan, 1993).

Individuals with BPD have a pattern of unstable and intense relationships (Kreisman, 1991), fears of abandonment and/or engulfment, undermining themselves in work-related situations. Premature death through suicide is more likely when there are

co-occurring mood disorders, substance-related disorders or other personality disorders.

From a biological perspective, D.F. Klein, a psychopharmacologically oriented therapist, held the view that borderline personality disorder is best considered as a set of personality variants within an affective disorder spectrum (Klein, 1977). This is similar to the view held by the Biosocialist, Millon (1985).

From a psychoanalytic perspective, although there are dissimilarities among the fine details when diagnosing BPD in patients, theorists generally believe that the borderline mother contributes directly to the development of BPD in the child through withdrawal of appropriate mirroring during the separation-individuation stage of development. For instance, psychoanalyst James F. Masterson (1981) stated,

> ... the key is the child's emotional experience of the withdrawal which
> he/she introjects as a withdrawing object relations part-unit. As a part of
> the intrapsychic structure, it may be reshaped and reorganized by later
> stages of development; nevertheless, with its affect of abandonment
> depression, it remains as the driving affective force of the disorder and can
> be identified as such in the transference acting-out. Thus arises the
> borderline triad: Separation-individuation leads to depression which leads
> to defense. (p. 133)

It is believed that the mother, for various reasons, is libidinally unavailable to meet the child's separation-individuation needs. This etiology can be compounded by possible nature aspects such as minimal brain damage, developmental lags or disharmonies. In turn, this sets up both internal and external defense mechanisms in the child. Internalized

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defense mechanisms are experienced as abandonment depression and they are defended against by projection and acting-out of the rewarding object relations unit onto the environment in behaviours such as clinging and compliance. Externalized defenses of projection, splitting, and acting out are clinically observed as distancing, critical, hostile attitudes; silence; intellectualization without affect; and paranoid-like attitudes. Masterson (1981) believed that confrontation, properly handled and directed, overcame avoidance and denial, allowing the patient to complete the circular process of resistance, confrontation and working through of feelings of abandonment. His theories derived from his observation of many, many patients and through personal research.

Kernberg (1986), in collaboration with others, developed a structural interview which combines the traditional mental-status examination with a psychoanalytically oriented interview focusing on the patient. It highlights the structural characteristics of the three major types of personality organization, focusing on the symptoms, conflicts or difficulties the patient present which provide data that permit classification into one of three personality structures: degree of identity integration, type of defensive operations predominating, and the capacity for reality testing. Kernberg believed that the patient's diagnosis determined the limitations to the psychoanalytic treatment available: a choice between supportive or expressive psychotherapy. If a supportive treatment was chosen, the patient may need support over many years or perhaps for life.

From a cognitive perspective, A.T. Beck (1990) worked on the premise that cognitive distortions are the basis of personality disorders. He believed that people develop anticipatory attitudes and expectancies through past experiences. We guide,

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screen, code and evaluate new experiences, and, in conjunction, use words to transform

the experiences to fit with our understanding of those words. The importance of

expectancies, sensitivities and language habits lies in the fact that they lead to the

distortion of objective realities, thereby channelling attention to and magnifying

awareness of insignificant features of the environment. Thus, they can obscure and warp

an accurate perception of reality. Such distortions are cumulative and result in an

intensifying downward spiral.

Through a combined perspective rooted in biosocial leaning, Millon (1986), who

based his theories on a social-learning matrix, conceived the borderline concept as a

particular form of significantly weakened personality organization. He did not believe

that the borderline label should be employed as a specific or distinct diagnostic type.

Rather, he suggested that it is best treated as a supplementary diagnosis that conveys the

dimension of severity in ego functioning and object relations.

Marsha Linehan is one of the newer members in the Biosocial field. She defines

herself as a cognitive-behavioralist. She uses dialectical behaviour therapy (DBT) which

she developed and evaluated with an empirical base of women who met the criteria for

BPD and also had histories of multiple nonfatal suicidal behaviours. Her findings may

not hold true for men or non-suicidal females. However, approximately 74% of people

diagnosed with BPD are female (Linehan, 1993). Although it is beyond the scope of this

paper to address the issues surrounding the high incidence of female diagnoses, there is

some belief that men who display similar characteristics and/or symptoms are often

diagnosed differently (e.g., with narcissistic personality, post-traumatic stress disorder, or

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even with Axis I diagnoses such as Bipolar Disorder).

Linehan (1993) defined BPD individuals as those experiencing emotional, interpersonal, behavioural and cognitive dysregulation. She states that it also is a disorder of the experience of the self. Her major premise is that BPD is primarily a dysfunction of the emotion regulation system resulting from both biological irregularities and environmental factors. She wrote,

> Invalidating environments during childhood contribute to the development of emotion dysregulation; they also fail to teach the child how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events. (p. 42)

The issue of emotion dysregulation, specifically in the area of anger, is further discussed in the literature review on anger suppression.

The onset of BPD usually occurs in the late adolescent years. The enormous flux and growth in physical, psychic and intellectual behaviours during adolescence can contribute to the problematic identification of BPD at that time (e.g., when an adolescent acts out violently is this a problem with rejection of parental guidelines, or possibly a criterion for early diagnosis of BPD?). Treatment of BPD has traditionally seen high dropout rates, whereas in DBT treatment the dropout rate has been shown to be much lower than in traditional therapy methods. A one-year follow-up has indicated efficacy in the area of controlling impulsivity, especially in reducing self-destructive behaviours (Paris, 2000).

A similar yet slightly different approach has been developed by Dawson and

MacMillan (1993). Their diagnoses of BPD were based primarily on the DSM-IV criteria, but their treatment program was based on the premise that people who suffer from BPD are intelligent, able and capable individuals who must be responsible, and held responsible for their actions. Dawson and MacMillan stated that they do not believe in hospitalization except in extenuating circumstances because it has been shown that these patients do very poorly in institutional settings, often regressing rather than improving. They believed the therapist should take a supportive stance, mirroring acceptable behaviour and working in a team oriented arena. They felt that everyone working with the patient must be educated in the area of relationship management and that consistency is imperative. Through unified help, the patient learns to take responsibility for their own actions and changes his/her behaviour accordingly.

Joel Paris took the stance that BPD was not related to just one of the previously mentioned perspectives. Rather, it is due to a combination of all three - biological, psychological and cognitive - factors. Paris stated that, "... personality *traits* are strongly heritable", and predicts that personality disorders "... are associated with a high intensity of personality traits that are more likely to be maladaptive, but biological factors are insufficient by themselves to cause disorders." (Paris, 1996). He wrote that BPD is an amplification of two personality dimensions: impulsivity and affective instability (Paris, 1998). Furthermore, he stated,

> The future borderline patient would begin life with an inclination to act quickly
> and to experience affects more intensely. When the psychosocial environment is
> favorable, these traits would be associated with an active and emotional

personality. However, when the psychosocial environment is unfavourable, these traits would be amplified and create significant dysfunction. (p.79)

When applying his research to BPD, Paris has found that much is still to be learned: biological factors are essentially unknown, there is no clear connection between psychological risk factors and the risk of the disorder, and only indirect evidence is linked to social factors. Yet, he stated that the most likely comprehensive model of BPD development would include all of these factors (Paris 1998).

Kroll (1997) stated that researchers and clinicians tend to discover causes and symptoms that best conform to their own theoretical conceptualizations. However, no matter what one's bias, the term BPD refers to an enduring pattern characterized by:

● impulsive and emotional instability;

● a dramatic interpersonal style that tends to shift between idealization and devaluation;

● splitting;

● cognitive difficulties that manifest under stress as mild disorganization (confusion) and transient altered states of consciousness;

● an inclination to think of oneself as a victim and to gravitate toward situations that either directly or symbolically reinforce the victim status. (p.82)

The following literature review examines the aspect of impulsive and emotional instablility, specifically in the area of anger suppression.

Anger Suppression

As with literature on borderline personality disorder, much has been written about anger. However, most of the literature has been written from the perspective of controlling anger (e.g., management of rage) rather than that of addressing the issue of anger suppression or looking at its sequelae. Thus the dominant theme in the literature on anger tends to revolve around acting-out and the negative aspects of expressed anger and rage. For instance, Kassinove (1995) defined anger as,

> a negative, phenomenological (or internal) feeling state associated with specific cognitive and perceptual distortions and deficiencies (e.g., misappraisals, errors, and attributions of blame, injustice, preventability, and/or intentionality), subjective labeling, physiological changes, and action tendencies to engage in socially constructed and reinforced organized behavioral scripts. (p.7).

Anger, as a feeling state, has been seen as negative, associated with distortions and deficiencies. This definition appears to be the most universally accepted attitude (Kassinove & Sukhodolsky, 1995). There also appears to be a strong leaning in favour of the perceived belief that expressing anger is to be avoided at all costs. Yet, there are many indications that anger that is not addressed in a healthy manner (i.e., 'self' validating), but rather turned in on the self (or other), can have strong negative consequences as well (Linehan, 1993).

Pudney & Whitehouse (1996), expressed it somewhat differently. In teaching children about anger, they have stated that anger is an emotion, not a behaviour: anger is good, healthy and normal and is used "to protect and motivate ourselves" (p.6). They

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stated that the behaviour that results from the emotion is one's responsibility and controlling it through appropriate behaviour is healthy, whereas suppressing it can be unhealthy.

Looking at anger in conjunction with affective suppression, several authors and researchers have investigated aspects of the positive effects of anger. Lerner (1985), working from a feminist perspective, suggested empowerment through anger expression. As defined in Kopper & Epperson (1991). Lerner stated that women are socialized against both feeling and expressing anger, so much so

> that when women do experience anger, they begin to ask themselves questions
>
> that serve to block or invalidate their anger, often leading to guilt, depression and
>
> self doubt. Lerner considered these responses to be actions taken against the self
>
> rather than behavior leading to personal and social change. (p.8).

Tavris (1982) looked at anger from a multi-dimensional perspective, making several important points. "... anger is not a disease, with a single cause: it is a process, a transaction, a way of communicating." (p.17,18). She stated that what we do about anger, how we think and speak about it influences what we do with it. In speaking of the relationship between anger and depression she stated,

> First, depression may be the sequel to anger. When anger is unsuccessful in
>
> averting danger or removing obstacles, when it does not restore your sense of
>
> control over the environment, you may eventually begin to feel helpless and
>
> apathetic. Studies of animals, children, and adults show that this kind of
>
> depression can be acquired as a result of struggling unsuccessfully in the world: it

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represents the collapse of effort, the perception that no energetic action will make a difference, that anger at injustice or abuse has no effect on ending the injustice or abuse. (p.103).

In discussing the effective use of anger, Tavris went on to show that studies led by Ernest Harburg, at the University of Michigan, on anger expression and physiological reactions indicated.

> ...there was one anger strategy that seemed to produce the lowest blood pressures of all, and it was neither exclusively to suppress anger nor to ventilate it. Harburg calls this approach *reflection:* waiting until the angry person who insulted you has calmed down (and presumably waiting until you have calmed down as well), and then trying to reason with him or her. (p. 110).

Her reflection on this was that "suppressed anger can be 'bad' if, by not revealing our feelings, the stressful situation continues: expressed anger can likewise be 'bad' if, in revealing our feelings, we make the stressful situation worse" (p.110). Although she stated that stress in itself does not cause illness. "Clinically pathological, psychosomatic, or self-defeating habits may be acquired, however, when *nothing you do* causes the stress and arousal to abate; when every action is met with inconsistent or controlling responses from the situation or person causing your predicament." (p.118). Similarly, anger can be a response to the sense of powerlessness a person may have in a situation, yet anger indicates that action is needed, thereby creating a double bind. Although some suppressed anger may make social life possible, feelings of victimization about anger suppression are likely to lead to negative consequences. A major factor in this

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determination would be how one has learned to cope with things when there is a conflict with one's expectations (that is, the level of ego functioning).

Linehan (1993) made a direct connection between emotional dysregulation, specifically with anger dyscontrol, and borderline functioning. Although she stated that there is "frequent, intense anger and angry acts", her work with depressed, parasuicidal borderline patients included "other individuals who are characterized by over-control and under-expression of angry feelings." (p.16). She went on to say, "These individuals rarely if ever display anger; indeed, they display a pattern of passive and submissive behaviors when anger, or at least assertive behavior, would be appropriate." (p.16). Linehan noted that under-expression appears to be related to fear and anxiety about loss of control or fear that this expression will lead to retaliation by anger targets.

Linehan (1993) defined a subset of borderline individuals who have histories of multiple attempts to injure, mutilate or kill themselves. They have behavioral patterns that include. but are not limited to, self-invalidation (which may include self-directed anger); inhibited grieving (with a tendency to inhibit or over control negative emotional responses including anger); and a tendency to fail "to display adequate nonverbal cues of emotional distress" (p. 10).

A strong correlation between low self-esteem levels and anger suppression has been shown in studies undertaken in conjunction with anger suppression at Concordia University (Balfour, 1996, Howell, 1990). Balfour stated,

... finding in this study is the powerful relationship ($r = -.48$) between self-esteem and anger suppression. Women who suppress their anger report low feelings of

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self-worth. It may be that women who feel less self-confident are unable to assert

themselves, particularly when it comes to expressing threatening feelings to

others. (p.83).

Although the above studies refer only to women, Tavris (1982) noted that this state of

affairs knows no gender boundaries.

Paris (1994) spoke of BPD clients turning anger inward when there is no way to

repair or change what has happened during their developmental years. He stated that this

leads to affective dysphoria: depression, anger turned inward, and chronic feelings of

emptiness.

In other literature of note, Beck (1999) offered a good overview of what anger is,

how it is generated, and what purpose or value it serves. Masterson (1985, 1988) looked

at anger from the perspective of the borderline syndrome and wrote of the client either

projecting unacceptable anger onto others, or taking the anger out on the self. He also

discussed the requisite detachment of affect needed in order to self-abuse.

The findings in anger literature, specifically those referring to borderline

personality disorder, that explore dysfunctional coping methods which contribute to

emotional disregulation (poor ego functioning), are further discussed in Chapter 3.

Art Therapy

Art therapy as a field in its own right did not gain much recognition until the

1940's. However, since then, art therapy literature has proliferated. Margaret Naumburg,

considered one of the 'founders' of art therapy, approached its practice from a

psychoanalytic perspective. Naumburg's "dynamically oriented art therapy" (Rubin, 1987) was based on art in psychoanalysis (i.e., the use of art as a means to release repressed materials through creative expression). She focused her work on the symbol being an unconscious communication that reaches beyond speech, "Art therapy enables the patient to translate the interior images of his unconscious into pictorial projections: the creation of such symbolic forms establishes a primary basis of communication with the therapist" (Naumburg, 1953, p. 3).

In the field of psychoanalysis, art had been used in therapy in an adjunct fashion from early on. Anna Freud (1970) believed that art was a form of sublimation, a mature defense mechanism that converted unwanted sexual or aggressive feelings and impulses into socially acceptable activities (e.g., art, music, etc.). Others, such as Jung focused his therapy on freeing creativity through making art, which he felt would happen as the self became healed. He began using art as a serious communication tool in therapy as early as 1916, as part of his personal growth process. Segal (1974) discussed Melanie Klein's theories on reparation: the use of symbolism is seen as critical for being able to "repair" the self. Masterson (1988) believed that an interest in creativity was the ultimate in self expression. He saw art as psychic energy, to be freed or sublimated by the self/ego. Greenspan (1989) talked about abstract feeling states that arise out of physical and physiologic sensations, ones which benefit from experimenting symbolically as well as getting in touch with preverbal abstracting of intentions. He theorized that knowing where developmental deficits occur can support specific ways of intervening.

Edith Kramer, whose art therapy practice is based in Freudian theory, emphasised

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art as therapy, rather than the psychotherapeutic use of art as a tool. Kramer (1971) felt

that the healing potential of art therapy depends on the psychological processes that are

activated during the actual creative act of making art. She saw this as differentiated from

other early practitioners, such as Naumburg, whom she felt used symbols to supplement

the spoken word, and consequently would have had to rely on psychiatric supervision for

her art therapy practice. In her earlier writing, she upheld that art can be used to model

ego functioning, "a sanctuary where new attitudes and feelings can be expressed and tried

out, even before such changes take place in daily life" (p. 219). Her belief was that

artistic expression is a sublimation of negative drives, and therefore, it reflects evidence

of higher-level ego functioning (sublimation is considered an ego defense mechanism of

higher functioning). Later, she (Kramer, 2000) expressed the opinion that it is primarily a

means of "supporting the ego. It harnesses the power of art to the task of fostering a

psychic organization that is sufficiently resilient to function under presure without

breakdown or the need to resort to stultifying defensive measures." (p. 18). She held to a

strong belief that art creation in itself is a therapeutic process. She stressed that the value

of the experience is in the actual process of making art, which gives form to feeling. As

there is no right or wrong way to make art, the client is always successful, and has the

opportunity to develop artistic skills to gain a sense of mastery. One can express oneself

without words, ventilate in the material, and see oneself mirrored in the created work.

She believed that it can force one to organize thoughts and actions. All this leads to

greater impulse control and improvement in other important ego functions.

Kaplan (2000) has researched the scientific aspects of the benefits of art therapy.

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listing several contributions of visual art to our well-being. Her list includes: facilitation of language acquisition; promoting creativity and problems solving; stimulating feelings of pleasure and increased self-esteem; and for some, providing an area of successful functioning, increasing the quality of life.

Kaplan (1994) examined the use of imagery and anger expression in her early research. This was followed up with a study on the efficacy of art therapy in anger modification programs (1996), which found that image modification "can serve as reflectors and reinforcers of the basic message conveyed during anger management training" (p. 73). However, the results also indicated that those who repress or deny anger fit a different category, and may require a different approach: one which would assist them to acknowledge their angry feelings first.

Silverman (1991), in her work with borderline disordered adults, stated:

Since art psychotherapy makes available concrete manifestations of the patient's

mental processes, it lends itself to the successful treatment of these individuals. In

addition, because of its unique capacity to render or evoke symbols and images

related to infantile experience, art therapy is of special value in the treatment of

severe pathology connected with primitive mental states. The art therapy

modality is particularly effective in supporting the reparative process of those who

have experienced early developmental impairment in their object relations (p.83).

This is also in keeping with the writing of Birtchnell (1984) concerning the use of art therapy as a form of psychotherapy.

Synthesis

"Victoria", the person described in the following case study, has been diagnosed with borderline personality disorder (DSM-IV). She has had numerous suicide attempts, appears to suppress her anger affect, and behaves in a generally passive manner. Her behaviour appears to fit the category of borderline anger non-expression (Linehan, 1993). In looking at her past (see *Personal and family history*, Chapter 2), the development of defense mechanisms and healthy ego functioning also appears delayed (Kaplan, Sadock and Grebb, 1994). The psychotic episode which precipitated her latest hospitalization encouraged her to explore ways to change these self-destructive patterns. Her positive response and almost immediate attachment to art therapy indicated that this could be a major therapeutic venue for her.

The following case study describes how Victoria utilized art therapy in an effort to increase her healthy ego functioning, and in the ensuing months was able to identify and begin working on several areas of importance to her. The following is a description of Victoria's sessions, art work, and therapeutic process.

CHAPTER 2

CASE STUDY

BPD theoretical and working frame

My theoretical frame is mainly based on Linehan's (1993) focus on validation, a belief in Victoria's inherent ability to make changes to her current situation. There is an emphasis on building a positive therapeutic relationship within a 'safe' environment where she would be able to explore and discover what Masterson (1988) expressed as the 'real self'. Both Linehan's and Paris' bio-psycho-social systematic approach to the underpinnings of BPD have strongly influenced my understanding and methodology.

Art therapy frame

As "qualitative research is an inductive approach to data analysis" (Maykut & Morehouse, 1994), client input allows the research to become an extension of the art therapy sessions and, at the same time, it enables a more rounded understanding of the client's experience. I felt that standardized forms or questionnaires would negate the objective of giving voice to the client. Consequently, in this research, I have used open ended probing which holds no right or wrong answer. I have employed participant input, and self-reports that look for alternative explanations for the account of the understanding of the experience which appears to be emerging. Feedback loops through ongoing meetings with the client were held after therapy ended, which allowed the researcher's understanding of the clients' subjective meaning to be incorporated. The purpose of these meetings was to allow the client the opportunity to explore and expand on what she

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discovered through her ongoing art therapy process.

The purpose of research is to find meaning. In this case, I am specifically looking for the meaning provided by the person being researched. With this client, I felt the most reliable interpretations would come from "the meanings and experiences of the people who function in the cultural web one studies" (Eisner, 1981, p.6). And, although "Qualitative rigor has to do with the quality of the observations made by an evaluator.... being factual about observations ... taking account of multiple perspectives, multiple interests and multiple realities." (Patton, 1990, p.480-1), I felt that Victoria's input along with her art, was critical to my understanding of what we experienced together. Therefore, sessional evaluations are an integral part of the findings.

The 'frame' aspect of the therapy was provided by offering a safe place within a transitional and holding environment. Winnicott (as cited in Lacroix, Peterson & Verrier, 2001), indicates the importance of having a transitional space to encourage growth, psychological integration and health. Creative activity encourages this development, and the therapy, the room, the art materials and the art product all contribute to the holding function which facilitates the transition.

Clinical setting

The art therapy sessions took place in a large urban general hospital which also serviced a psychiatric department with inpatient and outpatient clientele. Each person coming to this hospital is triaged through the emergency department and assessed by both medical and psychiatric personnel prior to admission. Care on the unit is offered in a

team setting with strong emphasis on pharmacology and getting the client well enough to be discharged to a continuing care program. While the client was an inpatient, art therapy sessions were held in a large occupational therapy room. Later sessions held with the outpatient group were in a smaller all-purpose room that provided privacy and space for art activities and discussions. Post-therapy sessions were held at this same hospital.

Client description

Victoria, a 42 year old, legally separated, unemployed female, dependent upon welfare, is currently living with her parents. She was admitted to the inpatient unit upon her presentation at the emergency department following a serious suicide attempt.

Personal and family history

Victoria is the eldest of three siblings. She has a younger brother and sister. In addition to a teenage son, the child of a short-term relationship, Victoria also has three other children, who live with their father. She has no access to the three children and reports that she bitterly regrets having given up custody to their father.

Victoria's parents are in their mid 60's. She stated that her mother, who has an undisclosed heart problem, was physically abusive to her when Victoria was a child. Her father, on urging from the mother would also, to a lesser degree, become physically abusive. She stated that her mother continues to be verbally abusive to her as an adult although she has an ongoing fond attachment to her father.

Victoria ran away from home for the first time when she was 11 years old, staying

with a family who was heavily into drug use and other illegal activities. At 13 she again ran away, this time making a suicidal gesture, and was placed in a reform school. Her stay at the school was short-lived. Once again, she ran away to live with this same family who moved continuously to keep ahead of the law. At this young age, she was introduced to the world of drugs and began abusing alcohol and chemical substances. At 14 she was raped by six men. There was nothing in the file to indicate what actions were taken (if any) concerning the perpetrators. Neither were there any indications that steps were taken concerning her psychological or physical well-being. Throughout her teens and early 20's there was evidence of significant PTSD symptoms that went untreated.

As a young adult, with an already long history of alcohol and substance abuse, she states that she lived a life of "dancing and prostitution" to support her habits. She was known to have engaged in violence when intoxicated.

Medical/psychological history

In her late teens, Victoria made her first serious suicide attempt, swallowing literally hundreds of benzodiazepines and anti-depressants while drunk at work. She awoke in hospital. Several years later she again overdosed and was hospitalized. For over a decade, the suicide attempts stopped. During this time, Victoria lived in a stable relationship, giving birth to her three children and making a home for them despite her alcohol and chemical dependence. Then, some dozen years later, there were four suicide attempts within a one-year period: in the first two instances she was hospitalized; in the next two, her older son found her and induced vomiting. This was the year Victoria's

marriage ended. She then entered a detoxification unit in an attempt to end her many years of polysubstance abuse. At the same time, her husband took their three children away to live with him and refused her access.

Four years ago, Victoria threatened to shoot herself with a gun at home, statingthat she had been depressed for about eight months. She was admitted to an inpatient unit at a local hospital. She once more entered detox, after which she stated that she would never attempt suicide again. Two years ago, she presented herself at this hospital for admission for depression. At that time, she had burned her feet in hot water, but she appeared to have disociated as she did not realize what she had done until the next day. She reported having been mostly depressed since entering detox several years before, and had become reclusive, spending much time watching TV. In the past two years, Victoria had gained approximately 100 pounds, and was very disappointed that detoxification had not gotten rid of her 'problems', even though she was no longer addicted to benzodiazepines.

Situation at time of hospitalization

Victoria's eldest son had lived with her for the past several years prior to this hospitalization. He had been in trouble with the law, was not attending school or work, and appeared depressed and stressed. She stated that he was not used to seeing her clean and sober and that he was having a very hard time accepting that she would not drink and drug with him. He had become verbally and psychologically abusive, although she felt that she was responsible for this because of her poor mothering and his current confusion

regarding the question 'who is this person I thought was my mother?'. She stated that

she began losing sleep, not eating properly, smoking and drinking coffee heavily, losing

the ability to take care of herself. She stated that at this point she became psychotic, with

strong paranoid delusions. She appears to have dissociated, and the situation culminated

in this latest very serious suicide attempt.

Treatment plan

Taking part in group art therapy at the hospital was suggested by staff to help

Victoria participate in ward activities and increase her social interactions. Individual

sessions were added to provide more one-on-one attention. It was also intended that the

art therapy experience would assist Victoria to develop insight into her current living

pattern and its long term repercussions through the use of a more tangible therapy tool.

Her stated short term goal in day centre treatment, where she continued group sessions

after discharge, was to take care of herself and add structure to her day. After the day

centre program, Victoria began attending an ongoing outpatient group so that she could

continue art therapy. Therapeutic goals were discussed, with Victoria stating that she

wanted to know how to prevent another suicide attempt. She expressed a strong interest

in art, explaining that it was one of the few fond memories she had of her youth.

With the above in mind, the focus of Victoria's treatment was to use her art to

examine the present, working toward an exploration of what was happening for her in the

moment, and what implications her lifestyle had on her behaviour. Little, if any,

emphasis was placed on the past, which was explored only when she brought it into the

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discussions, in order to see if there were patterns that might be investigated.

Art therapy sessions

Victoria came to her first art therapy group session while she was an inpatient in the psychiatric ward. She arrived in a manic state and was an enthusiastic participant from the beginning. Although she attended her first group session for its social aspect. she quickly came to understand that she was able to use her art productions to gain insight into her 'hidden' life. This both pleased and intrigued her, especially since art had such positive memory feelings for her.

During her first session, Victoria decorated a folder on both sides with words and colour. Words, in drawings, often relate to the issue of trust: can art be trusted? Will what I do be misinterpreted? (Furth, 1998). For a first session, these are not unusual questions, but sometimes clients are unable to verbalize them. Victoria then took a stack of paper and a box of oil pastels and proceeded to make 11 drawings (Figures 1-1 to 1-11. displayed in the order they were drawn). Her manic mood was in conflict with the depressed state in which she had first appeared at the hospital the previous day. She displayed both impulsivity and emotional instability in the session. She was friendly, voluble, flirting with another group member, Larry, who was also in a manic state. She spoke jokingly with him and anyone else who would interact with her. She took great care to let me know that she really liked art and that she was very happy to be there. Although she reiterated this several times, I felt that she was ensuring that she would be welcome in the room, or worried that I would not like her if she didn't assure me of her

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positive regard (possible idealization of the therapist). My response to this obvious need

for approval and display of neediness was to encourage her to speak about her work as

well as to praise her for her investment.

Figure 1:

From left, clockwise:

1 - five squares;

2 - three triangles;

3 - horizontal lines;

4 - swirling lines

5 - hand & fingerprints

6 - single triangle

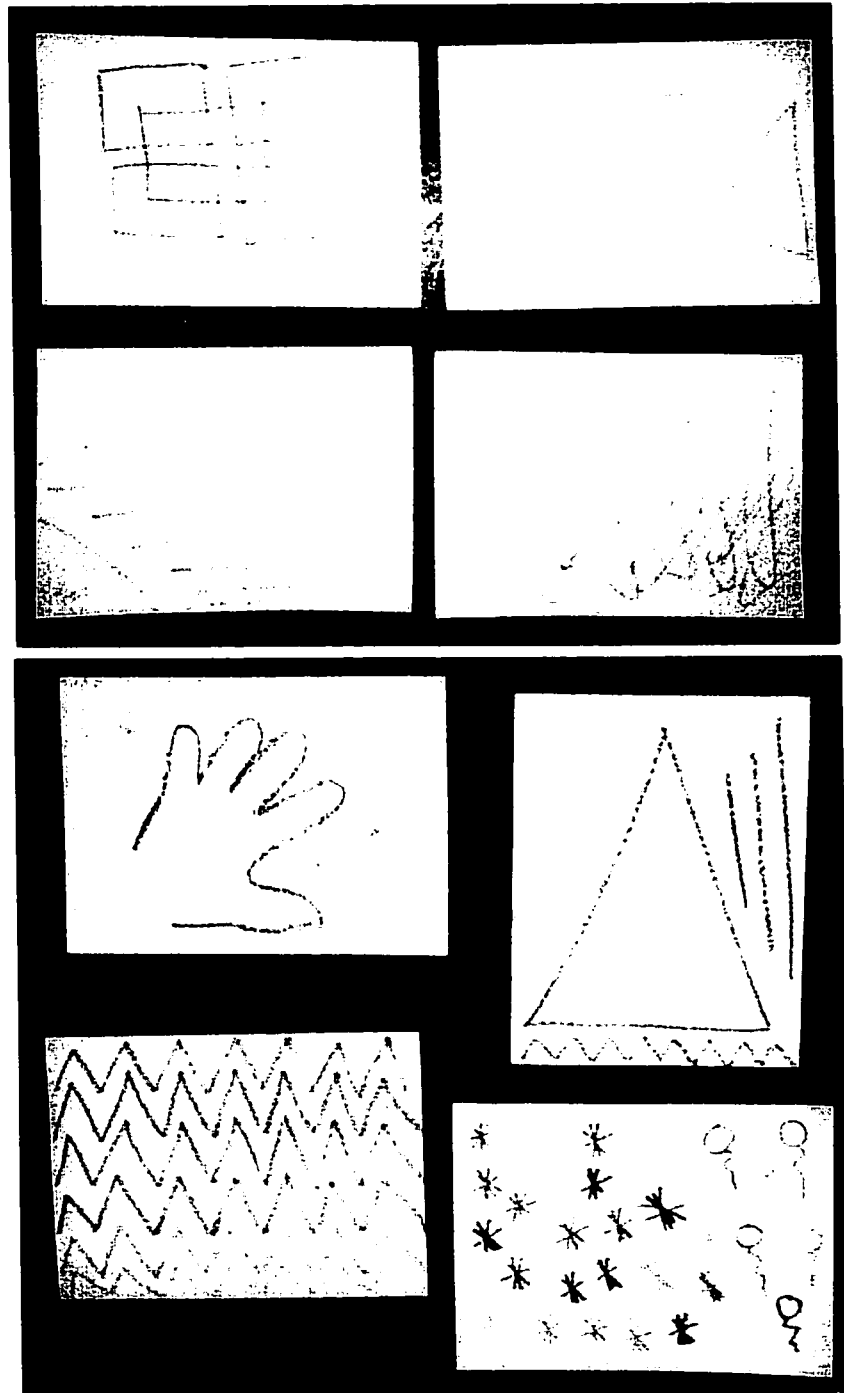7 - spiked lines

8 - asterisks & balloons

Figure 1 continued...

from left, clockwise

9 - self portrait

10 - tree & flowers

11 - birds
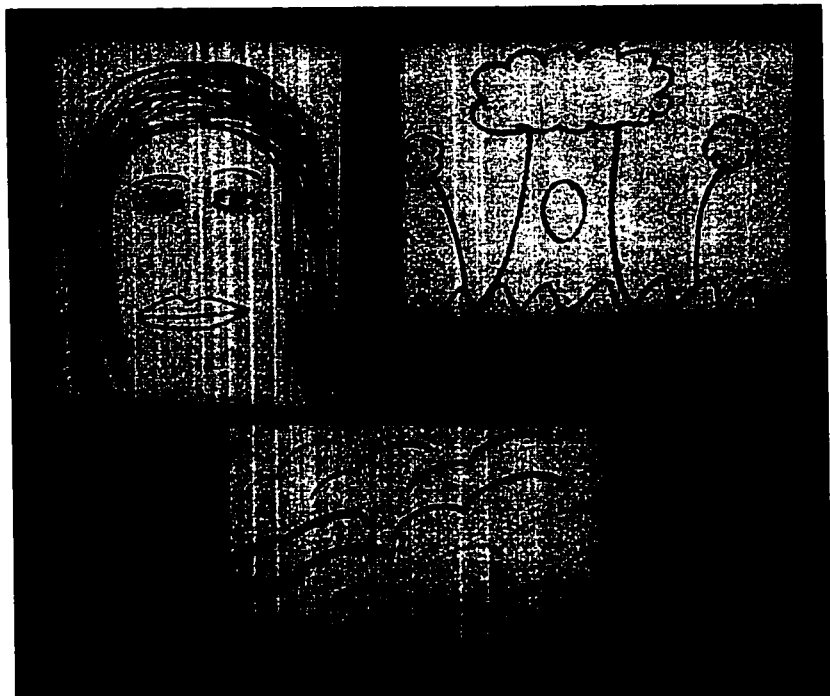
Figure 1. Eleven drawings from first session.

She was very open to discussing the art she had made, basically skipping along (acting as if the work had no meaning or value) until she came to the image of her hand (Figure 1-5), on which the marks are her fingerprints. Although she stated that it was her hand, its identity is not clear and it looks like any hand. Then she began to cry, stating that she had been arrested and fingerprinted in the past because of her behaviour. The image gave her direct access to the feeling content, something I do not think she was expecting to happen. Although she did not mention it, I wondered if she was also distressed by the fact that she had used her hands to make this latest suicide attempt. Robbins (1994) refers to the image of the hand as mirroring potential. Victoria had drawn an unconnected and consequently non-functional hand, which may also indicate her dissociated and non-functioning state. She re-composed herself and went on to

describe how she had been beaten up many times, but her worse beating had came from a policeman who had physically abused her on two separate occasions. There was no affective component when she began describing these acts. She then explained that she had turned to this policeman several years later when she began trying to stop doing drugs and alcohol. Her disclosure reminded me of the victim returning to the victimizer, thereby devaluing her own abilities and worth, It also brought up the question of whether or not the hand in figure 1-5 may have also represented that of the perpetrator (Furth, 1988).

Another image of note is the tree with the huge hole in the trunk (Figure 1-10). This hole could be indicative of the severe sexual abuse Victoria suffered as a teenager (she stated that she had been gang-raped at the age of 14) or possible feelings of emptiness (or both). The tree, in art, is symbolic of the self and art therapy assessment methods have theorized that damage to the tree is indicative of damage to the self (Brooke, 1996). Furth (1988), who sees the tree as a life symbol, discusses how the size and positioning of the damage to the tree provides age correlates to the life-wound. Using the measurements he offers, in Victoria's image, serious scaring would have occurred between the ages of 11 and 21. Victoria was 11 when she first ran away from home, and it seems reasonable to suggest that Victoria had been exposed to ongoing trauma during her childhood, adolescent and even adult years which would contribute to her borderline diagnosis (Rosenbluth, 1997).

I would like to bring attention to figures 1-2, 1-6, and 1-7. Much can be read in the shapes and movement within these images: sharp teeth, vibrating anger, layers of

anger, etc. This is consistent with the shapes found in the research findings of Kaplan (1996) in her work on images of anger.

Victoria had allowed herself to be extremely vulnerable in this first session, and there had been little evidence of ego boundaries. However, I felt that her ability to reflect and on some level express affect, augered well for continued therapy (Paris, 1998). Despite her affective instability (joking, crying, affect-less when it would have been appropriate to show affect...), her prolific art productions gave me a preview of what I would come to see as the basis of much of her internal conflict. The image can act as a substitute mirror. The "picture is an embodied image.... it symbolises a state not yet consciously known" (Schaverien. 1997. p.29).

The second group session saw a very different Victoria. She was quiet and withdrawn. She appeared depressed. again evidencing the mood reactivity typical of patients with BPD. She took only one piece of paper and the oil pastels, again she sat at the end of the table closest to the art materials, and proceeded to colour sections of the paper, each colour attached to the previous section (Figure 2). Robbins (1994) spoke of the individual's inability to tolerate too much exposure and so one hides both confusion and ambiguity in one's art. He went on to say that our ability to hold the clients' incompleteness shows respect for their defenses and discharge of affect in the art. which is an externalization of intolerable conflicts. Furth (1988), stated his resistance to paper-division theory in assessing art work, but expounded on Jolles', whose studies have shown that images drawn only on the left (as this one is) tend to indicate unconscious content. A person who is unconscious is impulsive and dominated by emotions. What

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happened next may lend validity to his theory.
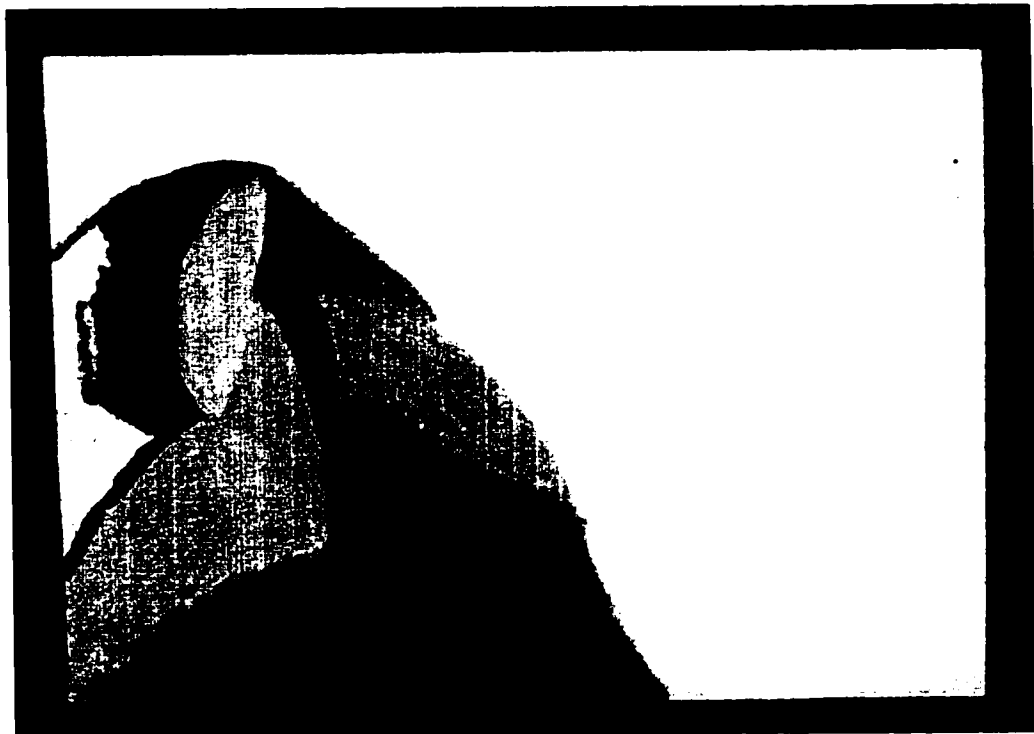
Figure 2. Incomplete oil pastel drawing, Session 2

Another group member, Jake, was talking continuously and this disturbed

Victoria. Without directly addressing Jake, she told him to "shut up". The expression of

her anger appeared to be impulsive, inappropriate to the situation, but she did not make

any efforts to control it. Tempers flared on both sides. This 'impulsive and emotional

instability' may have directly contributed to her inability to complete what she had begun

(Kroll, 1997). Jake said he would leave if he was bothering people, which he

immediately did. At the same time Victoria jumped up and stated that, no, she should

leave, which she did. Although in this situation Victoria did express anger, it did not

appear appropriate to the circumstances, and did not provide her with a means of

resolving the conflict. Rather, she became a victim of her own anger.

I continued with the group session although I felt distressed at not being able to reach either Victoria or Jake. This is one of the areas that Kroll stated it is easy for the therapist to get caught up in "protective attitudes ... designed to prevent the presumably fragile patient from feeling so badly about herself..." (p.83). I was definitely feeling this way, and consequently when Victoria requested an individual session, I scheduled it for the earliest possible date. She did not attend and when I followed up with her, she stated that she was in too much pain in her arm and shoulder to be able to attend. It is possible that this was a reaction to feeling unprotected and overly vulnerable in the art room, but she may have been able to only express this somatically (i.e., an acting-in of her anger).

Victoria did attend a group session held that same evening from 6 to 7:30 p.m. At the time of this session her mood had completely changed from the morning and she again flirted with Larry from the first group session. This time he reacted negatively, angrily telling her not to treat him that way. She appeared rebuffed, looked hurt and confused, but she did not verbally reply other than to say "sorry". Rather, she withdrew to her art work, which consisted of her using a stencil ruler to create shapes on white paper (Figure 3). Greenspan (1989) talks of this passive behaviour as being indicative of polarized behaviour-affective range and refers to it as "preverbal organization" (p.300). Through the stencil use, Victoria is symbolically indicating her ego developmental level. Case and Dalley (1992) also spoke of the abstract image having many interpretations, addressing issues of fusion and separation, or conscious and unconscious processes which one cannot see or speak about.

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Wagner and Linehan (1997) posit that biological and environmental factors

contribute to an "invalidating environment" (p.204) which disrupts the emotion

regulation system. Consequently, "it does not take much to provoke an emotional

reaction. Emotional intensity refers to extreme reactions to emotional stimuli, which

frequently disrupt both cognitive processing and the ability to self-soothe." (p.205). In

this session, the expression of another's anger appeared to precipitate regression for

Victoria, but she was able to use the structure of the art to hold herself together, to have

control over the situation and to self-soothe. She was able to control her more usual,

impulsive reaction. She did not leave the room or lose her temper and was able to

tolerate this rejection, although her 'I am victim' appearance was strong.
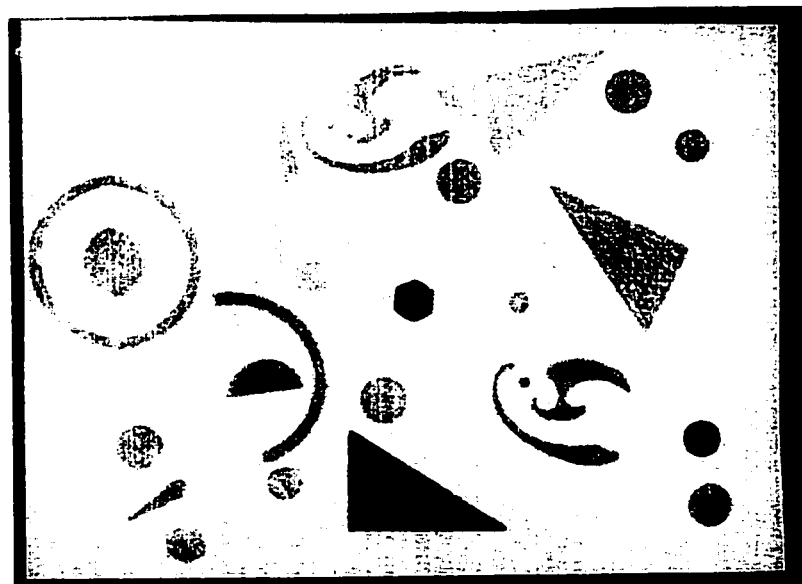

Figure 3. Stencil drawing.

Individual sessions followed this, where Victoria appeared to be checking me out.

She stated several times that she was really grateful to be there, how much she liked art,

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etc. I assured her that these sessions were for her and that she would be able to use them for her personal benefit. This seemed to please her. I sensed a strong neediness for acceptance and approval in her behaviour. Throughout the session I felt that she was presenting a verbal false self, which, according to Masterson (1988) "... does not set out to master reality but to avoid painful feelings, a goal it achieves at the cost of mastering reality." This defensive mask may possibly have been in direct response to her previous rejection in the group, and fear of a similar rejection by the therapist in these individual sessions. Rather than expecting unconditional positive regard (Rogers, 1951), Victoria appeared to expect rejection, and was willing to hide what was happening on an emotional level rather than face this possible rejection. Further, it would be important for her to hold the image of me as the 'good mother/therapist' and also to have me see her as 'good'.

Victoria continued to use abstract imagery. It appeared that she was able to use such art to self-soothe. She spoke often of how much she loved doing art. Although I believed this was true, I also had the feeling that she believed that saying this repeatedly would convince me that she was 'okay' and that she would stay on my good side. This appeared to be a continuation of what I saw as a fear of rejection, the presentation of the obsequious Victoria, repressing her needs and feelings to please the therapist, again revealing indications of under-developed ego structure.

In another individual art therapy session Victoria worked with oil pastels using black as the base for the images she made (Figure 4). The first piece consisted of the word 'love' written on this black background. This work was quickly followed by a

second creation in the form of a collage. Once Victoria had glued the figures on the page, she stated that she was finished. As we began to discuss the work, we were interrupted by another inpatient who stated she was here for the group art therapy session. I had made a mistake in timing, and had scheduled Victoria's session to run 15 minutes into the next group session time. I felt embarrassed by this mis-calculation in timing and apologized to Victoria. I asked Victoria how she was feeling with this situation. She stated that she was disappointed and felt cut off and unable to finish talking about her
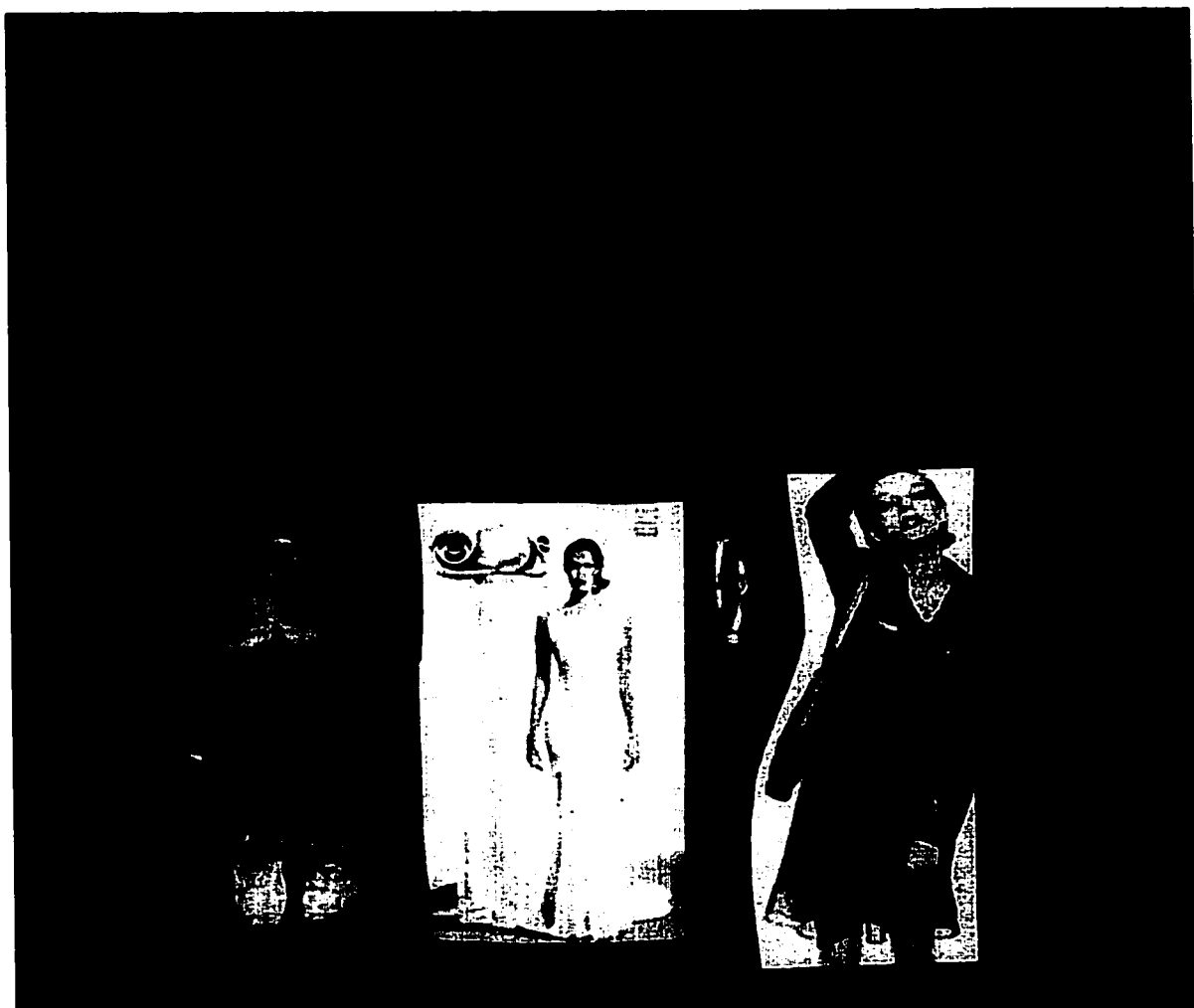

Figure 4. Love and three women.

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work, that she was just getting into it when we had to stop. I asked if we could discuss the work further in the next session, and she agreed to this. This was the first time that I felt Victoria was open with me concerning her feelings toward me and the sessions. Not only did she express her disappointment in an appropriate way, but she was willing to trust me with this information. I felt that the therapeutic alliance we had been building encouraged her to verbalize her feelings, and that the art therapy sessions appeared to be a somewhat safe place for her despite her fear of being rejected and/or misunderstood. It was to be two weeks before she attended another session.

Victoria did not attend the next individual session which had been scheduled for two days later, stating that she was too depressed to attend. My lack of attention to the timing of her previous session could have triggered a sense of abandonment and/or victimization, issues that both strongly influence BPD functioning. I wondered if her not attending may have also been passive-aggressive behaviour in response to her having stated her feelings (not living in the false self), or to my carelessness, or possibly to a combination of both.

Victoria was released from hospital and started the day program around this time, and so there was some difficulty in scheduling individual sessions. There was a two week delay between the abruptly terminated session and the next one. We began, with my prompting, by talking about what had happened at the end of the previous session. The issue was prominent in her mind, and she said she would like to go back to discussing her last art work, which we did (Figure 4). Victoria identified the person on the right as being the most comfortable, sure of herself and contented with her life. She

identified the female in the bottle as being caged, although she said this was not a bad thing, because it also protected the individual. The bottle could refer to Victoria's bottled anger, or even possibly to the holding function of the container. These idealized images may possibly reflect her fantasized self, or the self struggling to meet these ideals. She appeared to be finding ways of 'protecting' herself in her art. The abrupt ending of the previous session may have provided her with insight and recognition that life goes on after making a mistake, and restitution can be made. It may have also contributed to her willingness to verbalize her needs in this session.

After this discussion, Victoria returned to using a stencil ruler to create shapes (Figure 5). This appeared to be of a self-soothing activity, using very rhythmic movements while she verbalized different aspects of her life, such as her distress over the situation with her son. She said that she now has a very quiet way of life, one she is not familiar with but is definitely happy to live with rather than living in constant turmoil. She spoke once again of her sadness at the loss of her other children, with vague plans concerning how to get them back, or at least see them. She commented on her anger against her husband who she felt had tricked her into giving him custody of the children and then punished her by moving away and denying her access to them. However, once again, there was no apparent affect as she voiced her anger.

When she had finished making her image, she used tape to mount it on the wall. She stated that she 'knew the routine' and proceeded to look at the image, shift its position on the wall. She continued to look and shift until we had both looked at it from all angles. She then took the paper back to the table where she talked about one of the

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circles which reminded her of her having an abortion. She further identified the figure on the middle right of the picture as an angel. Furth (1988) speaks of how an abstract image provides a means of making "important associations to some problem that [she] could not draw realistically' (p. 82). When I inquired as to how long ago the abortion had taken place, she stated that she had actually had several abortions. This abortion, she said, caused her more emotional pain as she had been four months pregnant and so it was more like an actual child to her, and definitely much more difficult to abort than a little thought
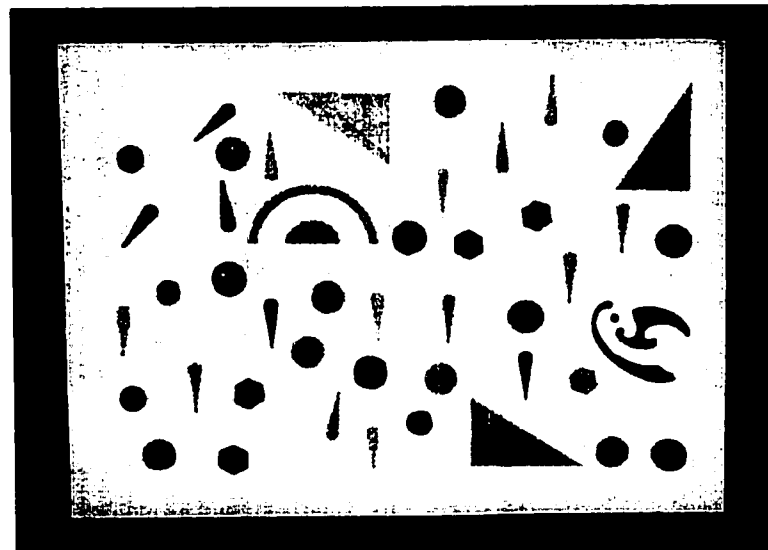
Figure 5. Stencil: Tears, angel and abortion.

of fetus. She then stated that she felt that God was forgiving her for this when she later gave birth to twins. She turned to me and asked if I thought that was true. I reflected to her that she did not need my approval, but that it might be important for her to forgive herself. At this point she said she did not, and that she felt like crying but wouldn't because she didn't want to be drained. As this was close to the end of the session, I

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expressed concern about how she was feeling prior to her leaving. She explained that the angel and other surrounding shapes in her latest piece of artwork were protecting the lost soul in the image and that she was comforted by this. I felt that the art had given her a venue to deal with overwhelming feelings of guilt. Further, I wondered if this discussion of abortions was a metaphorical reference to our aborted previous session and to her forgiving me for not having been a good-enough therapist, expressing her anger in the ambiguity of the art work where she would not have to fear retaliation. Robbins (1994) states,

> behind ... disturbances are deep wells of emptiness and loneliness that are the
>
> hallmark of a lack of primary identification and internalization. The therapist
>
> must not only be able to present structure and firmness in the relationship, but also
>
> care and concern, which facilitate the identification process. (p. 114).

My non-judgmental acceptance of this important information appeared to mark a turning point in her relationship with me.

Victoria had completed several images in a different group, and shortly after this incident she asked me to store them in her art therapy folder as she thought that it would be a "safer" place to keep them. I felt that she was likely seeing therapy as a reasonably safe place, one in which she could trust me (the therapist) to take care of things that needed holding, thereby creating an environment for further ego development.

Victoria's next art therapy session was a group session through the day program rather than her usual individual one. There was again a shift in her demeanour. She sat in a different seat location and was much less vocal. Although still quite focussed on her

art, she watched the other group members quite carefully. The person sitting directly across from Victoria projected a sexual fantasy on her. She stated (explicitly) that she felt Vicotria would behave in a particularly sexually provocative manner. Victoria did not respond although her facial expression indicated that she was affected by the comment. When the same statement was repeated by the projecter a few minutes later, Victoria again did not respond, although several other group members began fidgeting. On the third reiteration, with still no response from Victoria or the other group members, I intervened by asking the other person if she was able to see *herself* participating in the sexual act she had described to the group. Initially she said no, but after a few moments stated that, "probably . . .. yes, yes," she could. This would likely have been a good time to bring Victoria into the conversation and discuss what was happening for her, but instead, I reverted to the 'protective stance'. In trying to prevent her from being scapegoated, I took responsibility for her self care upon myself. Several group members then asked this participant to stop talking about the subject because they felt it was inappropriate. She, somewhat unwilling, complied. Victoria's contribution to the discussion was minimal. Basically, she stated that she liked working with the art and materials. She had used pencil crayons to trace stencils. She did not talk about herself, nor her feelings, nor about the actual art work. I realized that I, once again, felt as though I had let her down (i.e., by failing to protect her against the projections of the other group member). Further, I felt that Victoria had no defenses against the attack, that she felt she deserved this verbal abuse because of her history and her own sense of having no value. I found it very difficult to address the process that had taken place, fearful that I would be

seen as criticising her for not taking care of herself and reinforcing her belief that she was correct in her devaluation of herself. However, there was also the positive aspect of Victoria seeing other group members state their needs (i.e., for the member to be quiet) and having those needs honoured without negative repercussions.

As the day program was ending, and Victoria was now an outpatient, she was offered the opportunity to participate in a newly forming outpatient group which would meet weekly until mid-spring. She readily accepted this offer.

The setting and format for the outpatient group was somewhat different. Rather than the drop-in atmosphere of the inpatient group setting, with which Victoria was familiar, this was to be a closed group with an expectation that participants would regularly attend one and a half hour sessions on a weekly basis. A scheduled end date provided for six months of therapy. The room was more intimate and art supplies provided by the hospital were for the exclusive use of the six members of this group. Their art work would be placed in a locked space during the group's absence. In this setting, my art therapy theoretical approach was slightly more directive, providing discussion topics that led to art making activities. As the group progressed, the members were encouraged to become more autonomous in their art making activities.

In the first group session, folders to hold art work were created and members were encouraged to try a medium that was new to them. Victoria appeared somewhat quiet and withdrawn, although she did chose to work with paint, a medium she had not previously used. All members of the group were new to her, and they were mostly unfamiliar with each other. In later discussions, Victoria spoke of her social withdrawal over the past

years, and how easily intimidated she felt when confronted with new situations.

However, she stated that she was determined to change things, and so she would force

herself to come to the group. The perseverative nature of her art (see Figures 6-a and 6-b)
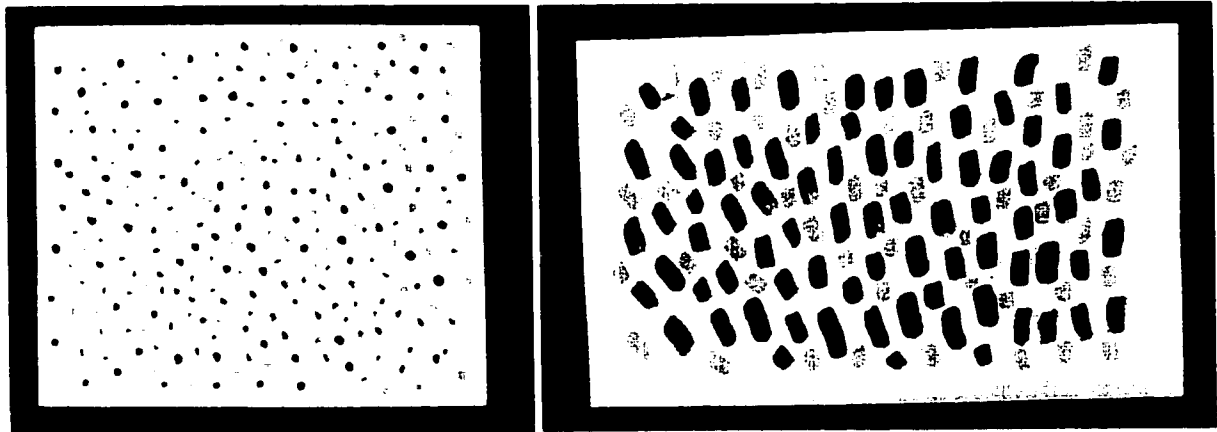
Figure 6-1 and 6-2. Two paintings.

seemed to provide her with the soothing quality she had derived when previously creating

stencil drawings (no stencils were available to this group). There was little discussion of

her work, other than to say that she enjoyed using the paints and vivid colours. The frame

that she created by not painting to the paper's edge, and the tight patterns, may well have

facilitated her coping with this stressful first session. As Robbins (1994) states,

> all therapy exists in relationships, and that the process of image-making –
>
> regardless of the artistic skill or lack thereof of the client – is analogous to and
>
> representative of the process of self-creation or healing that is the goal of therapy.
>
> (P. 127).

After many years of isolation, Victoria was now challenging herself to include a group in

her therapeutic process, and in developing a relationship with these group members. This

may have been somewhat overwhelming, as she did not attend the second session, and gave no reason for her absence.

The topic for the third session was self-boxes: the outside of the box was created using collage and/or other art materials that described something about oneself that the client believed others knew about them. Inside the box, work could be placed which described things that the members thought others did not know about them, but which they were willing to share with the group. The purpose of this activity was to offer the members the opportunity to work on sharing and relationship building and to further the self-awareness work that had begun in the previous week. Despite not having the benefit of the previous week's engagement, Victoria became highly involved, creating the work shown in Figure 7. She covered a tall, slim box with fushia tissue paper and covered that with images from her life: her son, sister, clothing she would like to have, a lounging woman and a dancer. The central figure on one side was of a semi-nude woman. I thought the image might refer to disclosure (exposure) and thought that she was possibly expressing how it felt for her to be talking about (exposing) herself to the group.

On the inside of the box she had placed three images which she described as her alcoholism, the loss of her daughter, and her shyness at being nude and overweight. Each of the images held special significance in Victoria's life, from an association to her shame at not being able to take care of her children; to the "bored lady" who represented her perception of her behaviour leading up to this psychosis: "I never did anything but laying in bed feeling sorry for myself"; to the embarrassement she endures in her "nakedness". It is interesting to note that the semi-nude on the outside is completely nude on the inside.

I saw this reference to nakedness as possibly alluding to Victoria's sense of her lack of

social and personal skills. Wadeson (1995) discusses the ambiguous nature of much of

the art work, how content remains unknown unless explained by its creator. At other

Figure 7. Self box and content.

times, the "graphic representation" (p. 79) can portray affect and point to important issues

such as feelings of shame and unworthiness. The disclosures Victoria offered in this

session indicated that she was developing a recognition that her problems may be related

to her long held negative self-concepts.

This level of intimacy was continued the following week in a two-person drawing

that fell under the topic "tell a story about yourself" (see Figure 8). In describing the

story. Victoria said she was feeling depressed when she arrived, and wanted to show it

(Figure 8-1). The self-portrait shows her tears, although her mouth is firmly closed. Her

head is significantly larger than her body, again possibly referring to her negative body

image. Victoria was later surprised to note that she drawn herself with no hands in this
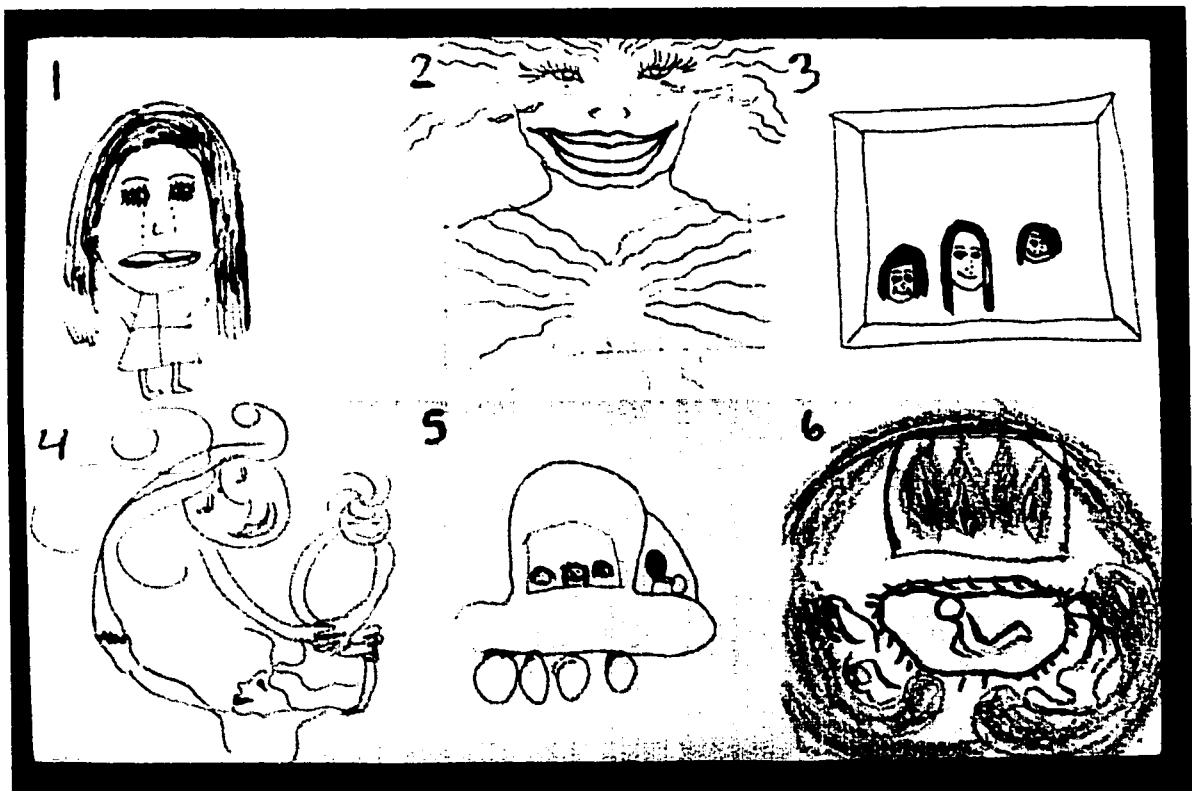

Figure 8. Two person story, panels numbered 1 through 6.

self-portrait. In the second panel of this drawing, her artistic partner took the tears and tried to turn them into joy (Figure 8-2). However, the image appears to reflect the intensity of Victoria's pain, enlarging it rather than diminishing it or pushing it away, opening the mouth, without voice. This happy/sad ambiguity is further reflected in the third image where Victoria's children are both smiling and crying at the same time (Figure 8-3). It appears that her artistic partner again attempted to caretake her by reuniting Victoria and her children (Figure 8-4). Nonetheless, the children are driven away by their father whose visage is covered by what looks like a black mask (Figure 8-5).

It is likely that her partner was put in the position of rescuer via projective identification, feeling Victoria's pain and anxiety, and trying to resolve these issues for her. The partner was able to transfer these feelings to the image, which in turn 'contained' the emotions for Victoria. In a later discussion of this series of drawings, Victoria expressed her anger at her husband for denying her access to the children, for hurting her deliberately because of his anger, and her consequent feelings of helplessness in changing the situation. In contrast to previous disclosures on this topic, this time Victoria appeared to be strongly connected to the anger affect, although the big and closed lips indicated that she was also holding in her anger (Wadeson, 1995). This work led to a further discussion of more realistic ways that Victoria could use to reconnect with her children.

Victoria missed the next two sessions, which were followed by a three-week break for the holidays. When she returned in January, she was again quiet and relied on

perseverative image making through various art materials. This lasted for several

sessions. The exception to this pattern was a session where clay was available. Victoria

described her work (Figure 9) as a depiction of an ongoing temple fantasy. Wadeson

(1995) suggests that patients placed in seclusion may be stimulated into hallucinations.

Although Victoria's seclusion was self-imposed, it is likely to have been a large factor

leading to her hallucinatory psychosis. The use of art to explore fantasy is supported by

Robbins (1994). He feels it is a way to use creative play situations to solve problems of

separation, growth and mastery.

> Playing with fantasies and images is what art is all about. Adults may need a
>
> chance to act out in the safe confines of a therapeutic relationship where there is a
>
> joint living out of imagos and roles. There can be some release of inhibition and
>
> constraint. (p. 41).

Clay's regressive qualities may have provided the means by which to make

Victoria's fantasy tangible, and through discussion, to examine it from a reality

perspective. Robbins suggests that the power of the symbol is that it is "a very special

way of communicating which pulls together many levels of the psyche and can make a

more accurate and complete statement of cognition than any verbal interpretation." (p. 41)

During this time period participants were encouraged to experiment with materials

and ideas, shifting to a more participant led focus as the group became more cohesive.

Also, two members left due to other commitments and one new member joined. As the

group re-formed, Victoria appeared to take on a more grounded demeanour. Her

willingness to share her experiences honestly with the group, and their revelations and

non-judgmental interest in her art work provided a forum for reflection. The positive

feedback she received here, as well as her strengthening relationships with group

members were beginning to influence her activities outside of the group. She stated that

her success here gave her momentum, and she knew she could return here for support

when necessary. Her art work became more bold, with Victoria exploring both materials

and motivation. She seldom created the stencil-like images of the earlier part of her

therapy. In discussion of her art, even images that did not provide obvious meaning for

her, did provide increases in self-esteem, as she was pleased with their artistic aspects (for

an example, see Figure 10). She stated that this piece was good enough to frame and put

on a wall in the new apartment she was looking for so that she could move out of her

mother's house. She commented that she had always been envious of others' skills, and

Figure 9. Clay temple and accoutrements.

now she had something of her own that she was proud of. This highly constructed work

is indicative of her ego building process, and the increased ego functioning is reflected in

her increased self-esteem.
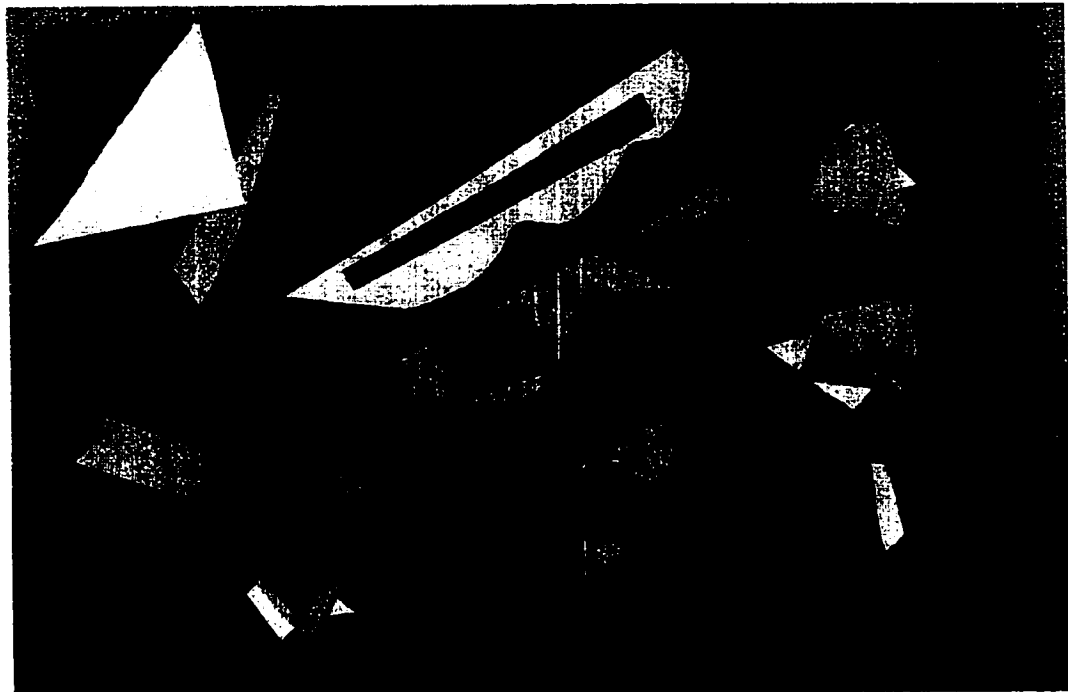
Figure 10. Ready for framing.

Although Victoria continued to miss group sessions from time-to-time, her level

of participation in art making remained high. She was also able to respond with

appropriate feedback when feeling challenged by other group members. For example,

when a member stated that she thought Victoria's art that day had been superficial, she

looked the other person in the eye and stated that she didn't agree. Two months earlier,

she had been speechless in the face of such a direct comment/criticism by another

member.

As the time of the group was nearing its end, the participants chose topics of

interest to them and a session on feelings ensued. Victoria was the first to suggest a

feeling: happiness. Other members suggested, in order, sadness, anger and regret. The

group created images that exemplified what each of those feelings meant for them. The

first three feelings were translated into collage by Victoria (see Figure 11). Happiness
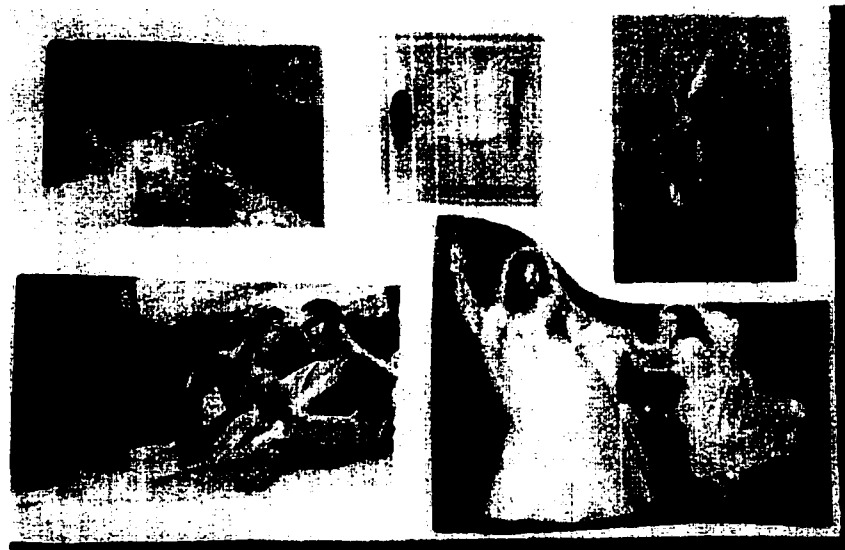

Figure 11-1 & 11-2 (continued next page)

Figure 11-3 & 11-4. Feelings: Happiness, sadness, anger, regret.

(Figure 11-1), as she was discussing it, was called a 'fantasy'. This suggested to me that

her ideas of what constituted happiness may have been seen by her as only available through her fantasies. She continued to explain the other images: sadness (Figure 11-2) referred to the loss of her children. These images are strongly evocative, and I wondered if the image of the woman's hands in, in the collage on sadness, were a form of retreat from, or pushing away, of the strong feelings it roused.

Anger (Figure 11-3) depicted the things she was angry about - injustice, homelessness and hungry children. Other than the first image on the left in this panel, the three collaged pieces looked more like they portray victims rather than expressions of anger. In her work, the first three feelings (happiness, sadness and anger) appeared to be depict other people rather than herself, a possible distancing of the feeling. This changed in the final feeling, regret (Figure 11-4). Victoria switched to oil pastels and did a self-portrait with tears (fewer than in Figure 8-1). This drawing was a much more personalized and 'in-touch' expression of her feelings than the collaged panels. Although her mouth was still closed, it was less tense and damaged looking than figure 8-1. Her eyes have lost their anxious look and stare directly at the viewer, more similar to how Victoria is now looking at herself in therapy. In comparing the four pieces, one can see that the images of fantasy move to images of reality, culminating in one which expresses the regret she has for the mistakes she has made. She said the regret she felt at this time was a most immediate feeling, the one with which she was having great difficulty coping.

The next, and final, art work that Victoria produced in therapy was a response to the 'feelings' art work from the previous week (see Figure 12). This image was created on a large (3' x 3') paper taped to the wall. After looking at the four pieces that she had

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completed the previous week (Figure 11-1 to 11-4), she chose the colours and a paint brush, then boldly and quickly completed this painting. She then sat, composed, waiting for the other members to finish their art. In discussion, members commented on how direct and sure of herself she appeared to be in creating this art. When she was asked to
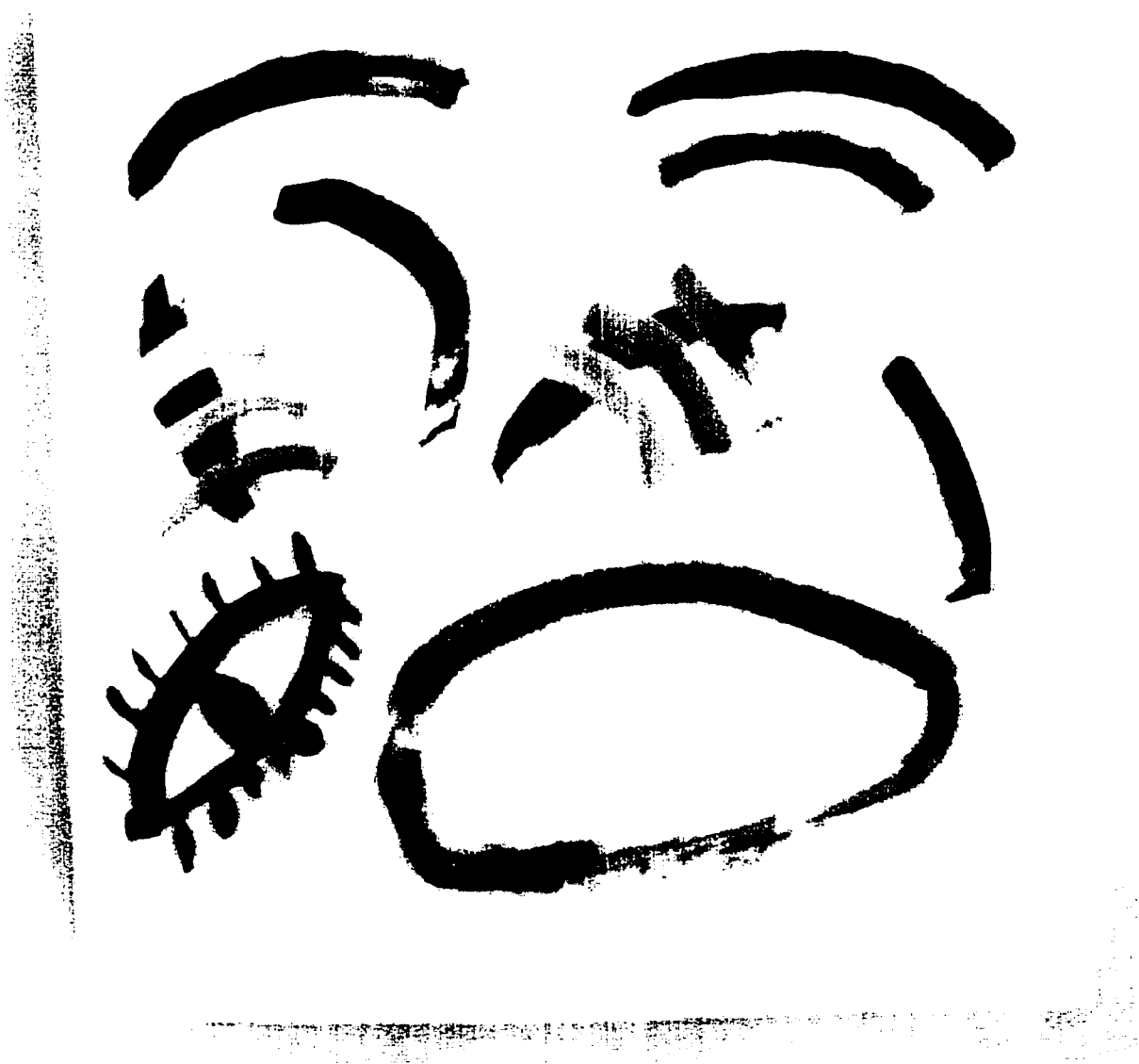

Figure 12. Artistic Response.

expound upon the painting, she stated that she was not able to associate it to anything personal. It was suggested that the painting had a Picasso-like appearance and the group suggested the possibility that it contained a face, maybe even a battered one. As soon as this was said, Victoria began to recognize it as a face - pointing out eyebrows, scars, and mouth. It is interesting to note here that Picasso's point in his art work was to provide another way of looking at things: to see from another perspective. Victoria later said that she thought the mouth looked like it was open, "... and it's like I want to scream out and I can't." She said that this was changing for her, bit by bit, as she began to find "...words to really say what I feel." She thought that the mouth could be symbolic of an opening to a brighter future.

Synthesis

Victoria came to the hospital because of a suicide attempt which occurred during an altered state of consciousness. She felt that her attempt was precipitated by the increasing and unbearable stress from an abusive situation with her son, and her social and emotional withdrawal from everyday life. She stated that she did not want to die; rather, she wanted help to prevent another attempt.

Victoria had two major factors in her favour concerning successful art therapy: she was motivated, and she associated art with a positive memory. Although this second factor is not a requirement for art therapy, in Victoria's case, it removed many of the barriers she had erected concerning social interactions. Group interactions gave Victoria another dimension in her quest for understanding herself through mirroring and feedback,

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touching on both the concepts of art healing (Kramer, 1987) and art therapy (Naumberg, 1953; Robbins, 1987, 1994; Wadeson, 1980, 1995). It also provided her with group related social aspects which had not been currently available in her life. The exposure to positive regard and new modelling techniques provided by both the group and the art therapist were utilized by Victoria to experiment with different patterns.

Despite the ups and downs of daily life, she remained dedicated to the process and derived great satisfaction from the fact that she had completed the her initial inpatient art therapy and the additional six months of outpatient group art therapy. "I didn't quit!"

CHAPTER 3

INTEGRATION AND DISCUSSION

Implications for anger expression in persons with BPD

Eckhardt & Deffenbacher (1995), in talking about BPD and anger, comment on the numerous ways one can be diagnosed as borderline with consequent heterogeneous characteristics. "... some clients [being] characterized by intense anger/affective arousal, and others having little problem with anger expression, but demonstrating serious impulsivity and parasuicidality." (p.40). In many cases, the intense anger is directed at those closest to the person diagnosed with BPD. However, much anger is suppressed, not directed at others, but rather held within the self. When anger is expressed by anger-in, the target is the self. I would like to suggest that this and the "little problem with anger expression' discussed earlier may be related to the concept of anger-in, evidenced by that very impulsivity and parasuicidality (and possibly suicidality). This anger may be ameliorated by feelings of self-blame (e.g., I deserve it; I'm not good enough; etc.), thereby creating a vicious circle of anger and self-blame. The inability to either flee or fight (deal with the anger) would leave the individual with the only other option - to freeze (depress). Findings from Howell's (1990) experiments in thought suppression show that it was more difficult for non-depressed persons to suppress happy thoughts than it was for depressed persons to suppress negative thoughts, pointing to the impact of mood on thought processes and information processing. This supports the concept that if you are depressed you think negative thoughts about yourself, and effectively, negative thinking contributes to further feelings of low self-worth, helplessness and futility

(depression). Initially, Victoria often referred to herself as too fat and ashamed of the things she had done. She believed that anger was a negative feeling that should not be felt or expressed. Consequently, she suppressed it, resorting to fantasy to deal with stress rather than relying on her healthy ego functions. Eventually, this culminated in a serious suicide attempt.

However, Youcha (1991) stated that people with BPD can have insight into the immediate causes of their stress and anxiety, and went on to say that supportive and exploratory psychotherapy, focusing on content and process has worked best in his experience. This is the tact that was taken with Victoria.

Implications for ego development and anger expression in persons with BPD

I have used the term ego development to describe the evolution and maturation of the individual's personality and the conscious awareness one has of their personal existence. Ego (self) development refers to development within the framework of biological (genetic), psychological (psychic) and social (environment) influences. The ego has tasks that need to be performed to maintain personal integrity and cope with the outside world. These tasks develop as the infant grows to physical maturity.

Storr (1980) expounds on the fact that we are born helpless and dependent and continue to be, at least partially so, longer than any other animal. He feels it is reasonable to assume that the human infant has little awareness of his own capabilities. As a child matures, and is brought up in a welcoming home, treated well and accepted, it is likely that the child will feel like a worthwhile person. During this maturation process, the child

integrates this positive regard into a sense of self-worth through introjection. "Whereas his self-esteem originally depended upon repeated affirmations of his worth from outside sources, it eventually comes to depend upon something within himself which has become 'built-in' as part of his own personality." (p.98-99).

However, in the face of adversity, people tend to continue to feel both helpless and hopeless. Instead of imagining that they can improve their situation through their own efforts, they believe themselves to be at the mercy of events, and also, in some way, that they are to blame. They become resigned to an out-of-control life that is regulated by outside forces. However, Storr (1980) states,

> Their resignation is more apparent than real; for, like the rest of mankind, they not only suffer, but also resent what has caused their suffereing, [sic] However, instead of their resentment being mobilised to make an effective 'aggressive' response, it is repressed and turned inward, showing itself only in self-blame and self-depreciation. (p.97).

Victoria eventually abdicated her role in life for fantasy. When at the age of 11, she ran away from the abuse she received at home, she ran to another abusive situation, this time the world of reform school and drugs, to which she became addicted. One form of abuse was replaced with another and life did not improve, as she had imagined it would. Her efforts to improve her situation were futile: whatever she did she was subjected to abuse. Victoria continued to be victimized, allowing both drugs and fantasy to substitue for affect. She often stated early in therapy that she felt unreal, "I was numb". Storr goes on to say,

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Without a certain assertion of his own personality, a person ceases to exist as definably distinct.... feels defeated. What he is usually quite unaware of is that there is another side to his masochistic submission of self; a violent, hostile and destructive side of which he is usually so frightened that he has erected formidable defences to make sure that it does not emerge. No human being can experience repeated defeats at the hands of others without resenting them.... By repressing his destructive hostility, he has at the same time deprived himself of those positive features of aggression which would allow him to assert himself when necessary, stand up to other people, initiate effective action, 'attack' difficult problems, and make his mark upon the world. I said that helplessness and hopelessness march hand-in-hand: let us add hostility to make a triad of the 'h's. (p.102-103).

In Victoria's case, she stated that she has felt tremendous anger, but also felt that she could not deal with the causes of the anger (did not have the resources), nor could she find a constructive way to express it. Eckhardt & Deffenbacher (1995) state that the combination of personal characteristics (level of ego development), and the person's state in the moment are relevant in how a person handles anger, and that anger is elicited when there is a blameful or shameful attack on one's ego identity, or trespass on, or violation of personally defined rules for behavior or events. This hold true in this case: Victoria felt trespassed, blamed, shamed and violated, with no recourse, and so suppressed that unacceptable emotion.

In terms of how one deals with negative emotional issues, Linehan (1993) states, the research on emotional behavior suggests that .... the individual must first learn

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to experience and label the discrete emotions that are hard-wired into the neurophysiological, behavioral-expressive, and sensory-feeling systems. Then the individual must learn to reduce emotionally relevant stimuli that serve either to reactivate and augment ongoing negative emotions or to set off secondary dysfunctional emotional responses. (p.45).

The skills necessary to regulate emotion were not available to Victoria when she began therapy. She states that she was "hanging on by a thread" (another reference to her suicide attempt?), and was currently terrified of killing herself in a state of disociation. She was desperate to find a way to prevent this and bring her life to some level of normalcy. The art appears to have provided the beginning: the ability to experience and name affect.

Art Therapy as a facilitating environment

In looking at Victoria's art work and her reflection on it, this case study appears to confirm that art therapy can function as a primary psychotherapeutic modality, used in this instance to facilitate exploration of suppressed anger for a person with BPD by providing a medium into which anger can be projected. The art can hold the anger and provide sufficient discharge so that the need for self-harm can be mitigated. The current *controlling* of anger can be changed into *containment*: holding it, living it and then letting it go. Winnicott's transitional space is used as a safe place to discharge affect into the art work.

Robbins (1994) spoke of the paradox of feeling overwhelmed when intimacy and

closeness create anxiety, and yet being threatened with those same feelings when faced with separation and autonomy (the dilemma of the borderline condition). Yet, he felt that both these states are required to create, and that the flux between creating art and moving away from it assists in ego development. "...he or she must master such ego functions as frustration tolerance, judgement, discipline, and loss of control, all of which are parts of an emerging ego that can integrate self and other" (p. 161). This relates directly to the literature on psycho-social development where the child has not learned ego-syntonic ways of dealing with the world. Robbins goes on to say that exposure to art therapeutic activity puts the patient in a position to develop a sense of effectiveness and mastery through trial and error, with the therapeutic setting providing a secure and supportive environment.

Through examining Victoria's ongoing art work we can follow the progress of ego development through the sessions. Even without words, there is an ongoing unconscious process taking place, the embedded meaning in the image is not yet available to the conscious mind (Schaverien, 1990). That images come before knowledge was seen with Victoria's art productions where she was able to find personal meaning later, taking out the pieces, examining them and seeing the changes depicted. When too much exposure was threatening to her she was able to have the art hold her "fragile and frightened sense of self" (Robbins, 1994, p. 160). As an example, whenshe later looked at the self portrait drawn in the first art therapy session (Figure 1), she said, "no tears". When asked to elucidate on the comment, she noted that she had drawn a second self portrait with tears in a later session (Figure 8). Her comment was "So, I think I'm getting in touch better

with my feelings. I'm crying because I'm so angry." This self-reflection is indicative of both better affective awareness and increased ego functioning.

Storr (1980), in talking about working with his psychiatric patients writes,

I wrote of the distancing effect of putting things into words. Paintings also have this effect; but are often more useful in that they can be kept and looked back upon, whereas words may be forgotten unless recorded. Some patients produce serial paintings which most interestingly record their emotional progress.... I have often suggested that the patient should paint [their mood]; and a number have found that this enables them to master the mood, rather than continuing to feel at its mercy (p.53).

Victoria had tangible proof that something was changing for her. She had emphatically stated that she had difficulty crying, just about never did, but here she was able to cry through the art process, where her anger was held until she was ready to see it. The anger, not verbalized at the time of doing the image, remained safe. The art held the anger until she was ready to recognize it and name it.

In reflecting on her art process, Victoria spoke of her feelings about making the art objects, stating that she was "trying to create here... cause I'm not an artistic person, so I'm trying to express myself. It's a relief to have someone listen to me, actually listen, and I felt comfortable enough to talk about the art work and what it means to me." Robbins (1994) speaks of the client offering their image and "regardless of the 'aesthetic value' of that picutre, he or she is offering a view of him- or herself" (p. 127). In this same vein, Spaniol (1994) states, "Art therapists are familiar with the empathic power of

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having one's artistic processes and products witnessed by others. By extension, we can imagine the validation clients may feel after publicly exploring their struggles and successes in living with mental illness" (p.71). Victoria expressed feeling this validation and believed it confirmed the changes she was making: the awareness and ego growth that is a direct outcome from her art making process. It has enabled her to leave her seclusion of the past six years. Robbins (1994) states that human relationships are too dangerous for some people. When this happens, they focus their emotional investment in fantasy and unconscious processes. For a fortunate few, "the world of creativity becomes a major source of externalization. Here in the safety and confines of a sphere when they are completely in charge, the individual dares to bring forth and concretize the early representations of past conflicts" (p. 39).

Victoria felt that the success she achieved in making art encouraged her to make additional life-style changes during the period of therapy. It was the thread she clung to.

CHAPTER 4

CONCLUSION

Amalgamation

It has long been agreed that anger is inappropriately expressed in borderline

personality disorder - either through aggression or suppression. Recent studies have

researched the effects of anger suppression in diverse areas such as: gender identity (Cox,

Stabb & Hulgus, 2000), which supported the hypothesis that girls suppress anger at

higher rates than boys; eating disorders (Deffenbacher, e t. al., 2000; Farinon, 2000),

which self-silencing and anger suppression were significantly and positively correlated to

negative eating behaviours and eating disorder symptomatology; life-style behaviours

(Musante & Treiber, 2000), which showed that teens high in anger suppression reported

consuming more alcohol and were less physically active than their peers; recurrent

headaches (Venable, Carlson & Wilson, 2001), which found that the mixed-headache

group scored high on measures of anger suppression. As these studies indicate, anger

suppression effects many areas of personal functioning. And, inherent in anger

suppression is the non-verbal aspect, a problem for clients participating in traditional

therapies.

Kassinove (1995) asks, "What cues do people use to judge that a person is angry?

For the practitioner, the most available cues are the client's verbalizations, facial

expressions, and body language, as shown in the psychotherapy office or verbally

reported during sessions" (p. xvi). In Victoria's case, she was unable to verbalize, and

her body language had a lethal aspect to it. At the time of her hospitalization, she was

psychotic, unable to care for herself, and did not have a conscious awareness of her anger suppression. However, this did not prevent her from participating and benefiting from the art therapy sessions. Her positive regard for art, and her ability to be expressive through the materials provided, made it a very good choice of therapy. As awareness comes through a willingness to see ourselves, and in keeping with the notion that art facilitates the ability to see ourselves, Victoria found a modality that provided her with a tool that did not previously exist in her repetoire. The art appears to have provided her with both a mirror and a different voice - a voice that could grow as she re-grouped.

Primary processing (early ego development) recognizes the use of symbolism (art) as a means of representing something that one may not have words to describe. Early childhood takes place before a concept of time; it is a time of preverbal thinking. Brenner (1973) stated.

> "In primary process thinking ... [something] may be represented by a single thought or image. In fact verbal representation is not used nearly as exclusively in primary as in secondary process thinking. Visual or other sense impressions may appear instead of a word, or for that matter instead of a paragraph or a whole chapter of words. (p.48, 49).

Victoria's fond remembrance of Grade 2 art enabled her to find a means of expression, to find a beginning that provided an alternative to fantasy and isolation. Landis (1970) stated, "the outcome of sustained isolation is immersion in (normally) unconscious fantasy, which leads, in effect, to the disappearance of the external world. Under this condition there can be no individuality." (p.2). He wrote that if ego boundaries are too

weak, a person will be unable to differentiate between internal fantasies and external realities. He implied that "hallucinations and delusions are not necessarily restitutive phenomena but may be the outcome of a collapse of ego boundaries." (p.9). Federn (as cited in Landis, 1970) stated that this requires both inner and outer boundaries to be involved, for if, "the inner boundary is too strong, then the person is walled off from his feelings and no longer senses his affects as connected with his ego" (p.9). As the stress and Victoria's feelings of uselessness and helplessness increased, so did her retreat into fantasy. Eventually, she could not return, became psychotic, and attempted suicide by hanging. "My anger just hangs on me". The shock of waking in a hospital with no memory of having made a serious suicide attempt provided Victoria with the impetus to seek help. In her first art therapy session, still in a state of psychosis, she used art as a means of communicating her distress and began an examination of her world. McNiff (1998) has stated,

> The physicists are telling us that we create reality through our interactions with the world. This idea has great significance for creative arts therapy. If we create and recreate our worlds, then it follows that a therapy based on the practical application of this theory will have major scientific ... relevance. (p. 46).

In this case study, Victoria used art therapy as powerful tool in restructuring and reconstructing her world.

Future research

McNiff (1998) states that "The participation of the artist-researcher in the

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experimental activity distinguishes art-based research from the controlled laboratory experiments of physical science. Personal involvement in the experiment is a direct extension of the practce of creative arts therapy." (p.42). This personal involvement is part of art therapy's special flavour. However, because this particular research paper is a client and therapist as observer theoretical exploration, there is a strong possibility of bias. The client could have provided what she thought the researcher wanted to hear. Similarly, it would have been very easy for this therapist to have influenced the client, even on a unconscious, covert level. Nonetheless, this case study has shown a likely connection between Victoria's anger suppression and lowered ego functioning. It has also shown a connection to her suicide attempt, her anger suppression behaviours and her diminished ego functioning at the time of her suicide attempt ("My anger just hangs on me: I've never had a place to put my anger: I feel useless and helpless").

Further studies in the area of anger suppression might include a number of issues that became more clear to me as I completed this research. For one, it has long been held that women and men experience and express their anger differently. Research into a comparison of male and female anger expression/suppression patterns in art productions could be illuminating. What is the possible connection with the high incidence of females diagnosed with borderline personality disorder (as stated previously, women comprise 74% of the BPD population), and the ramifications of any findings hold great interest for me. Because the art acts as a container, examination of anger expression, conscious and unconscious, can be performed both during and after the art making process, as the art remains long after the emotion.

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Another area of research might be in combining dialectical behavioral training

(DBT) with art therapy. It has been shown that people with BPD respond well to

cognitive training and dialectical behavior training (Beck, 1990; Linehan, 1993; Richards

& Gross, 1999; Silver, 1998). Furthermore, treatments in cognitive training have been

shown to lower anger suppression as well as outward negative expression (Dahlen &

Deffenbacher, 2000; Deffenbaher, et. Al., 2000). Although this would of necessity be a

more structured approach to art therapy, the art might be used as both a training tool, and

as an assessment tool in determining the efficacy of the training.

One other area of interest would be to research the correlation between women's

anger suppression and self-image and how that is depicted in art. In a similar vein,

studies on how anxiety or fear of possible retaliation, levels of self-efficacy, and degree of

assertiveness, effect anger suppression/expression. At present the field of anger

suppression and art therapy research is very open to new and exciting paths.

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APPENDIX

CONSENT FORM

Art Therapy Research Paper
Alice Madden, Student
Masters of Art, Creative Arts Therapies Program
Concordia University

I, _____, the undersigned, give permission to Alice Madden to photograph my art work for inclusion in her Master's Research Paper in the Creative Arts Therapy Program at Concordia University.

I also give Alice Madden permission to have access to my medical files for a period of one year for the purpose of writing her research paper.

I understand that both myself and the setting where my art therapy sessions took place will be kept strictly anonymous and that no identifying information will be given in the research paper. I also understand that I may withdraw my consent at any time before the research paper is completed, without explanation, simply by contacting Alice Madden or her supervisor, Irene Gericke (514) 761-6131, extension 2017. This decision will have no effect whatsoever on my art therapy or any other aspect of my medical treatment.

I have had an opportunity to ask any questions about the implications of this consent, and I am satisfied with the answers I received.

I have read and understood the contents of this form and I give my consent as described above.

Signature: _____

Date: _____

Witness: _____

Date: _____