

Art Therapy and Eating Disorders:
Introducing Feminist Post-structuralist Perspectives

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ABSTRACT

Art Therapy and Eating Disorders: Introducing Feminist Post-structuralist Perspectives

Renata Butryn

This research addresses the phenomenon of eating disorders, specifically anorexia and bulimia, among contemporary Western women, with an aim to examine the usefulness of integrating feminist post-structuralist perspectives into art therapy for the understanding and treatment of female clients. Feminist post-structuralists share a socio-political view of eating disorders as attempts to reconcile the oppressive contradictory femininity that is embedded in Western gendered mind-body discourse, within which femininity is equated with the devalued body and construed negatively as the “other” of the masculine mind-as-self. Feminist post-structuralists describe the gendered mind-body discourse as pervading popular culture and psycho-medical theories and treatments, which tends to reproduce the contradictory femininity and undermine recovery. This theoretical study is based on reviews of feminist post-structuralist literature related to eating disorders and of literature on feminist art therapy, postmodern art therapy, and art therapy with eating disorders. The study demonstrates that feminist post-structuralist perspectives can increase art therapists’ awareness of: the role of socio-political context; patriarchal assumptions in theories of human development and in symbolic representation; gender and power issues in treatment; and how visual, metaphorical, concrete, and embodied aspects of working with images can subvert the gendered mind-body discourse and ultimately reconstruct women’s femininity.

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This research paper is dedicated to the women I have met, who have experienced eating disorders, in recognition of their struggles.

Table of Contents

Introduction.....	1
Overview.....	1
Prevalence of Eating Disorders.....	3
Eating Disorders as a Feminist Issue	5
Implications for Art Therapy	6
Methodology	7
Organization of the Paper	8
Chapter 1: Gender, Subjectivity, Body	11
Overview.....	11
Theorizing Femininity, Subjectivity, and the Body with Freud and Lacan.....	12
Deconstructing Femininity, Subjectivity, and the Body with Post-structuralists.....	16
Chapter 2: Deconstructing Eating Disorders	20
Overview.....	20
Deconstructing Contradictory Discourses of Femininity	21
Gendered discourses of control and excess.	22
Discourses of absent feminine identity.....	24
Femininity and popular discourses of identity and body.....	26
Femininity and popular discourses of health.	28
Problematizing the Psycho-medical Discourse of Eating Disorders	30
Eating disorders as diagnostic categories.	30
Psycho-medical treatment and prevention of eating disorders.	33
Redefining resistance, prevention, and treatment.	35

Chapter 3: Feminist Art Therapy	38
Overview.....	38
Gender Bias in Art Therapy Research and Publication	38
Critique of Patriarchal Approaches to Research and Theorizing	39
Gender as a Social Construction.....	40
Gender Bias in Psycho-medical Theories.....	41
Wellness through Empowerment.....	43
Image-making and Symbolic Representation	45
Embodied Image-making.....	47
Chapter 4: Postmodern Art Therapy	50
Overview.....	50
Postmodernism and Post-structuralism.....	50
Critique of the Pathology Perspective	51
Toward a Wellness and Empowerment Perspective.....	52
Therapeutic Process of Reconstructing Meaning	54
Client-Therapist Relationship	55
Social and Communal Aspects of Art Therapy	57
Chapter 5: Art Therapy and Eating Disorders	59
Overview.....	59
Theoretical Perspectives	59
Goals of Art Therapy	62
Group Art Therapy.....	62
Art Therapy Compared to Verbal Treatment Modalities.....	64

Art Therapy and Community Involvement.....	65
Role of the Art Therapist	65
Therapeutic Functions of Art.....	67
Art as a mediator in the client-therapist relationship.....	67
Art as an indicator of conflicts and defences.....	68
Art as an assessment tool.....	69
Self-integrative and ego-strengthening functions of art.....	70
Art as a means to reconnect with one's body.....	72
Art as a means to develop the ability to symbolize.....	73
Art as a metaphor for psychological space and boundaries.....	74
Art as a transitional object.....	75
Art as a means to exploring socio-cultural context.....	76
Chapter 6: Summary and Discussion.....	77
References.....	87

Introduction

Overview

Of the approximately sixteen million Canadian women alive today (Statistics Canada, 2007), five hundred thousand will be diagnosed with anorexia nervosa or bulimia nervosa during their lifetime (Walsh & Devlin, 1998; Zhu & Walsh, 2002). Yet, the long-term efficacy of current treatment methods is relatively weak. This theoretical research turns to feminist post-structuralist perspectives to address the phenomenon and treatment of eating disorders, specifically anorexia and bulimia diagnosed among girls and women in contemporary Western society.

Feminist post-structuralists view eating disorders as attempts to resolve the contradictory femininity that is embedded in Western gendered mind-body discourse, within which feminine identity is construed negatively as “other” of the masculine mind-as-self. Feminist post-structuralists suggest that mainstream psycho-medical treatments are ineffective because they are also embedded in the gendered mind-body discourse, thereby reproducing the oppressive contradictory femininity and ironically reinforcing eating disorders. Using literature reviews, the paper explores the usefulness of feminist post-structuralist perspectives for art therapy; it examines the extent to which published art therapy literature is affected by the gendered mind-body discourse and the extent to which art therapy can subvert the discourse, toward a better understanding of eating disorders and more appropriate treatment of female clients.

Eating Disorders as Diagnostic Categories

Research by Bemporad (1997, as cited in Polivy & Herman, 2002) provides evidence of both anorexia and bulimia existing in ancient times, although not as prevalent as today and with possible variants in symptomatology. The diagnostic category of anorexia nervosa emerged in the late nineteenth century (Gull, 1874, as cited in Malson, 1998) and that of bulimia nervosa shortly thereafter (Polivy & Herman, 2002).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), distinguishes three categories of eating disorders. This research focuses on two clinical eating disorders, namely anorexia and bulimia, as diagnosed among contemporary Western women; the third, sub-clinical category, namely eating disorders not otherwise specified, applies to individuals who do not meet all criteria for anorexia or bulimia. *DSM-IV* (American Psychiatric Association [APA], 1994) lists the following diagnostic criteria for anorexia nervosa: body weight 85% less than expected, intense fear of weight gain, disturbed perception of body weight or shape, and amenorrhea in postmenarche girls and women for at least three consecutive months. A restricting subtype of anorexia nervosa is distinguished from a binge-eating/purging (bulimic) subtype. The *DSM-IV* lists the following diagnostic criteria for bulimia nervosa: normal body weight; recurrent episodes of binge eating followed by compensatory behaviours, such as purging, fasting, or exercising, at least twice weekly for at least three months; binge episodes are characterized by their relatively short duration and by a sense of lack of control.

Prevalence of Eating Disorders

Within the Western population, eating disorders, including anorexia, bulimia, and eating disorders not otherwise specified, affect all ethnic and social-class groups (Crago, Shisslak, & Estes, 1996), particularly females, who make up 93% of hospitalization cases for eating disorders (Public Health Agency of Canada, 2002). The lifetime prevalence of anorexia and bulimia is estimated at 3% (Walsh & Davlin, 1998): approximately 0.5% to 4% for anorexia, 1% to 4% for bulimia (Steiger & Séguin, 1999, as cited in Public Health Agency of Canada, 2002). The lifetime prevalence for binge eating disorder (a subtype of eating disorders not otherwise specified) is 3.8% (Bruce & Agras, 1992). Females account for approximately 90% of all eating disorder cases (Steiger & Séguin, 1999, as cited in Public Health Agency of Canada, 2002). According to a report by the Public Health Agency of Canada (2002), since 1987, the number of hospitalizations for all three types of eating disorders has increased by 34% among girls under 15 years of age and by 29% among women aged 15 to 24 years; it is not clear whether the increased number reflects an actual increase in the incidence of eating disorders or an increased number of referrals to hospitals. Concerns have been raised about partiality of and gaps in the hospital data (e.g., Gucciardi, Celasun, Ahmad, & Stewart, 2003; Public Health Agency of Canada, 2002), and it is generally agreed that the hospitalization data under-represents the actual number of eating disorder cases, reflecting only the most severe subset. Given the continued increase in the number of hospitalizations, treatment issues have become more significant.

Mainstream Treatment Approaches and their Efficacy

Complicating the treatment of anorexia and bulimia are comorbidities in areas that include depression, bipolar disorder, and anxiety disorders (i.e., obsessive-compulsive disorder, panic disorder, and social anxiety disorder) (Woodside & Staab, 2006). Although the associated mental illnesses suggest a combination of biological, psychological, developmental, and social factors in the aetiology of eating disorders, the fields of medicine, psychiatry, and psychology continue to focus on eating disorders as individual psychopathologies to the exclusion of relevant social factors and without regard for the gender discrepancy in the prevalence.

A recent review (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007) of current treatment methods for anorexia found that the main focus is on restoring weight and on reducing psychological and behavioural symptoms, and to a lesser extent, on decreasing depression and anxiety. The overall efficacy of popular treatment methods for anorexia (i.e., medication, behavioural interventions, or a combination of these) was found to be weak; the exception was a combination of restoring weight and family therapy, which was found to be more effective for younger, non-chronic patients with anorexia. A similar review (Shapiro, Berkman, Brownley, Sedway, Lohr, et al., 2007) of popular treatment methods for bulimia (i.e., medication, behavioural interventions, or a combination of these) found the use of medication to be effective in the short term, and cognitive behavioural therapy to reduce the core behavioural and psychological symptoms in both the short and the long term. Malson and colleagues (Malson, Finn, Treasure, Clarke, & Anderson, 2004), a team of feminist post-structuralist researchers who conducted a review of studies on treatment efficacy, found the long term follow-up

outcomes to be generally unfavourable, including a high rate of drop-out and relapse, especially among individuals diagnosed with anorexia. Malson and colleagues argue that, while there are alternative explanations for the eating disorders (including psychodynamic, feminist and socio-cultural perspectives), the poor treatment efficacy is related to the fact that within the psycho-medical field eating disorders are regarded and treated as “‘real’ *individualized* clinical entities” (p. 474). Consequently, psycho-medical treatment efficacy is studied in terms of treatment outcomes, which prevents an exploration of other meanings or experiences associated with eating disorders.

Eating Disorders as a Feminist Issue

The *DSM-IV* diagnostic categories of eating disorders have been criticized as being “artificial.” For example, some argue that the diagnostic criteria are too restrictive by including amenorrhea (Cachelin & Maher, 1998, as cited in Polivy & Herman, 2002; Garfinkel, Lin, Goering, Spegg, Goldbloom, et al. 1996, as cited in Polivy & Herman, 2002) or the 85% weight cut-off (Polivy & Herman, 2002). The diagnostic criteria of self-starvation in anorexia and of binge-eating and purging in bulimia produce an apparent distinction between the two disorders; however, the similarity of their core symptoms (i.e., body dissatisfaction; preoccupation with food, weight, and shape; and ego deficits) has led some to a spectrum hypothesis (VanderHam, Meulman, VanStrien, vanEngeland, et al., 1997, as cited in Polivy & Herman, 2002, p. 188) and, in the case of feminist post-structuralists, a continuum theory (Malson, 1998). Feminist post-structuralists extend this continuum theory to include any female who experiences distress over food, eating, weight, and body image – experiences which have been

correlated with the development of eating disorders. Body image problems, in particular, are widely considered a “normative” female experience (Chesters, 1994; Polivy & Herman, 1987, as cited in Moulding, 2007), a manifestation of what it means to be a woman in contemporary Western society where eating disorders represent the extreme of the continuum (Malson, 1998).

Research into the gender discrepancy has implicated clients’ identification with the female gender role in the aetiology of an eating disorder, suggesting a need to study what aspects of femininity are relevant to the development of eating disorders (e.g., Behar, de la Barrera, & Michelotti, 2001; Hepp, Spindler, & Milos, 2005; Murnen & Smolak, 1997). Particularly valuable in identifying these aspects are feminist perspectives which recognize that identity is socially constructed and uses gender as an analytic tool rather than a social category (Stewart & McDermott, 2004). Feminists offer an “analysis of gender as a system of power relations embedded in other systems of power relations, and [an] analysis of the multiplicity and instability of identity” (Stewart & McDermott, 2004, pp. 538, 539). Feminists who integrate post-structuralism analyze the social construction of gender, subjectivity, truth, and health, and include in their research the clients’ views of treatment and eating disorder experiences. This approach allows researchers to investigate and problematize popular and psycho-medial discourses in relation to the development and maintenance of eating disorders.

Implications for Art Therapy

In light of physical complications related to eating disorders, art therapy is not a substitute for medical care, but is often used in conjunction with it. This paper presents a

review of the extent to which art therapy adheres to the psycho-medical model and the extent to which it has or has not integrated feminist post-structuralist ideas about the role of feminine identity, in relation to eating disorders. The aim of this research is to answer the following question: how might feminist post-structuralist theories inform art therapy with women diagnosed with eating disorders? The question is based on the assumption that feminist post-structuralist views on the role of gender in relation to eating disorders can provide a valuable heuristic for art therapists, making for a more authentic therapy.

Methodology

The study has a theoretical design. According to Junge and Linesch (1993), theoretical research “critiques and integrates existing theories in an attempt to generate new knowledge and theory” (p. 66). Using data from theory, the researcher begins with finding limitations and contradictions in a theory (or theories) under investigation. Next, using the primary tools of logical analysis, evaluation, and synthesis, the researcher attempts to eliminate these limitations and inconsistencies. He or she integrates and extends the current understanding by developing either a new theoretical model, based on new system paradigms, or a critique of a particular theory and its underlying paradigms.

The focus of this research is eating disorders, specifically anorexia nervosa and bulimia nervosa, as diagnosed among women living in contemporary Western society. This research provides a critical examination and an integration of data based on a review of the feminist post-structuralist literature on eating disorders, the literature on feminist and postmodern approaches to art therapy, and the literature on art therapy with eating disorders. Feminist post-structuralist perspectives on the function of the social

construction of gender in relation to the phenomenon of eating disorders are reviewed. The aim is to provide preliminary ideas for integrating the feminist post-structuralist perspective into art therapy practice.

Organization of the Paper

The study is comprised of the following six chapters:

Chapter 1, Gender, Subjectivity, Body, describes the feminist post-structuralist challenge to mainstream psycho-medical theories, specifically, the tendency to neutralize and make assumptions about gender, subjectivity, and the body. These assumptions are contrasted with feminist post-structuralist views which are informed by the psychoanalytic notion of subjectivity as constituted in language, fundamentally embodied and gendered, fragmented, shifting, and decentred. Feminist post-structuralist theory is presented as going beyond the psychoanalytic view by extending the constitution of subjectivity to include the material dimension of discourses and viewing subjectivity as not only decentred and shifting but multiple and dispersed.

Chapter 2, Deconstructing Eating Disorders, is a review of feminist post-structuralist literature on eating disorders. First, feminists present eating disorders as embedded in contradictory discourses of femininity which are reproduced in popular culture. Second, feminists problematize the psycho-medical reproduction and reinforcement of eating disorders through positivist assumptions. The concern throughout this chapter is with an analysis of how contradictory discourses of femininity and the psycho-medical discourse are embedded in a more general gendered mind-body discourse.

Chapter 3, Feminist Art Therapy, is a literature review of feminist perspectives in art therapy. Obstacles to feminist art therapy research and publication are addressed in relation to the gendered hierarchy of expertise in the mental health profession. Feminist approaches to theorizing and researching are described and contrasted with masculine approaches. A gender bias in traditional theories of human development and the implications of the bias for understanding and treating women's mental health and illness are considered. A feminist critique of the pathology perspective in the traditional psycho-medical model is presented and related to the patriarchal notion of representation in modern art. The pathology perspective is contrasted with the wellness and empowerment perspective. The chapter ends with a description of a feminist notion of embodied image-making.

Chapter 4, Postmodern Art Therapy, is a literature review of postmodern perspectives in art therapy. A brief overview of the similarities between postmodernism and post-structuralism is given. The postmodern approach to therapy emphasizes wellness and psychological growth, in contrast with the psycho-medical approach which emphasizes pathology and universal and reductive theories. The postmodern view of meaning-making is presented and related to: art therapy, the therapist-client relationship, the community, and art as product and process.

Chapter 5, Art Therapy and Eating Disorders, is a review of literature on art therapy with clients diagnosed with eating disorders, looking at the extent to which art therapists adhere to traditional theories of human development and the extent to which they attend to feminist concerns about gender and social context. Art therapy is contrasted with traditional verbal therapy approaches, including cognitive-behavioural

therapy. Authors' views on group therapy, community-based approaches, and the role of the art therapist are reviewed. A considerable portion of this chapter describes the multiple therapeutic functions of art with special attention devoted to how art can empower clients and enable women to have healthier relationships with their bodies.

Chapter 6, Summary and Discussion, presents a summary and an integration of the reviewed literature. Implications of feminist post-structuralist perspectives for art therapy with girls and women diagnosed with eating disorders are presented. The main concern here is how art therapy can subvert Western culture's gendered mind-body split and the contradictory femininity that eating disorders attempt to resolve. Limitations of this research and directions for future research are described.

Chapter 1: Gender, Subjectivity, Body

Overview

An idea that feminists share (e.g., Burns, 2004; Eivors, Button, & Warner, 2003; Gremillion, 2002; Guilfoyle, 2001; Hardin, 2003a; Lester, 1997; Malson, 1997, 1998; Moulding, 2003) is that eating disorders express a patriarchal oppression of women – as exemplified by mainstream psycho-medical theories of eating disorders that neutralize and make assumptions about gender, subjectivity, and embodiment. In their attempts to challenge, theorize, and politicize those assumptions, feminists (e.g., Malson, 1997, 1998; Robertson, 1992) have relied on the psychoanalytic theory of Freud and Lacan¹ and on post-structuralist theory. Feminists have found these theories particularly useful because of the emphasis on the role of language in the constitution of both social meaning and gendered, embodied subjectivity (Robertson, 1992). Post-structuralism has been additionally useful to feminists because it goes beyond Lacan's exclusive focus on linguistic practices, by theorizing social meaning and subjectivity as constituted not only in language but also in material practices (Malson, 1997, 1998; Robertson, 1992). The idea that socio-cultural linguistic meanings and material practices play an integral part in the constitution of feminine identity and women's experience of embodiment has informed the feminist theorization of eating disorders. Feminists use this idea to examine anorexic and bulimic subjectivities, to situate eating disorders in socio-cultural and gender-specific contexts, and to reveal and analyze the disorders' patriarchal basis.

¹ Credit must be paid also to post-Lacanian theorists, especially French psychoanalytic feminist theorists. See Malson (1998) and Robertson (1992) for a discussion of the relevance of their ideas to the feminist post-structuralist understanding of eating disorders in females.

Given that many art therapists are influenced by psychoanalytic theory, a discussion of the psychoanalytic contributions to feminist theory is relevant. However, since an exposition of psychoanalytic and feminist post-structuralist theories is beyond the scope of this paper, what follows is a very brief synopsis focused on only those theoretical aspects that feminist post-structuralists have found most helpful in their understanding of eating disorders among girls and women. This account begins with Freud's and Lacan's psychoanalytic theorization of the body, subjectivity, and gender identity, and is followed by a description of the post-structuralist framework, with an emphasis on its feminist appropriations.

Theorizing Femininity, Subjectivity, and the Body with Freud and Lacan

For Freud and Lacan, subjectivity, the body, and gender are deeply interrelated. Understanding subjectivity requires an analysis of its constitution in the body. According to Freud's psychosexual theory of development, an infant is born with an undifferentiated and ungendered sense of self, and he or she develops an integrated and gendered identity based on interpretations of his or her biological body (Mitchell, 1974). Malson (1998), Mitchell (1982), and Rose (1982) explain Freud's theorization of subjectivity in the following way: the infant's interpretations are largely unconscious and determined by a pre-existing social hierarchy of values; Western society attributes the highest value to the phallus; the phallus that stands for the sexual difference (defining gender as a presence or an absence of the penis). Thus for a girl, psychological differentiation of femininity and masculinity begins when she interprets her body as missing a penis, which she associates with power due to its greater size and visibility

and (Malson, 1998). This interpretation translates into a negatively constituted feminine identity, defined in terms of lack and weakness (Malson, 1998). Freud's view of femininity as the effect of society's phallogocentric ideas about the body, rather than femininity as determined by biology by or an intrinsic essence, has led some feminists to regard his theory as a deconstruction of patriarchal ideas about the constitution of feminine identity (Mitchell, 1982; Rose, 1982). Consequently, Freud's psychoanalysis can be useful in understanding eating disorders in the context of a patriarchal society (Malson, 1998).

Lacan's rereading of Freud further emphasizes one's interpretations one makes of his or her body (Mitchell, 1982; Rose, 1982). Like Freud, Lacan thinks that the child is born undifferentiated from the rest of the world. In the move towards the "imaginary" – Lacan's term for the original presymbolic order that contains conscious, unconscious, perceived, and unperceived images – the child acquires a sense of bodily unity and unity with the outside world (Robertson, 1992). Later, during the "mirror stage," the child acquires a sense of being a separate entity (Robertson, 1992): upon seeing a mirror image of him or herself, the child begins to identify with it and eventually refer to it with the self-referential "I" in the spoken language (Mitchell, 1982; Rose, 1982). According to Lacan, the child is attracted to the mirror image, idealizes it and refers to it in its absence, because its coherence contrasts with the child's vulnerability and uncoordinated body movements (Robertson, 1992). Robertson explains that, for Lacan, referring to this visual image as "self" is a misrecognition because the mirror reflects only a part of the child's body (concealing its movements, sensations, the unconscious, etc.); the appearance of the mirror image as an object external to the child's body splits the child's original subjective

imaginary order into the internal self and the external other resulting in a decentred and fragmented subjectivity. Thus, for Lacan, the liberal humanist idea of the self as whole, uniform, and homogenous is a fiction (Robertson, 1992); however, this fact is often concealed from us because the unconscious prevents us from being transparent and rational in our self-knowledge (Malson, 1998).

According to Malson (1998), Lacan takes Freud's theory further toward the social dimension by introducing the idea that language enables a child to represent his or her body and thereby to develop a gendered self-concept. With the acquisition of language, the child enters the primarily language-based "Symbolic order." Here, socio-cultural values, norms, and knowledge equate the phallus with the law of the Symbolic order, thus privileging the male. As "the signifier" of difference, the phallus stands for sexual difference in terms of presence or absence of a penis. According to Lacan, because the phallus is "the signifier" of sexual difference (signified in terms of presence or absence of a penis), identity, and also desire, a girl's interpretation of her body as lacking a penis constitutes her female identity negatively as "not-all," as an "impossible contradiction" (Malson, 1998), as "not-I," as "Other" of identity (Benvenuto & Kennedy, 1986, as cited in Malson, 1997). "In so far as the phallic function rests on an exception (the 'not') which is assigned to her, Woman is excluded by the nature of words, meaning that the definition poses her as exclusion" (Rose, 1982, p. 49). The awareness of having no penis prompts a girl to undergo a psychological castration of the symbolic phallus whereby she forgoes of her desire. Instead, she "asks to be desired – for that which she is not" (Robertson, 1992, p. 61), defining herself not for her own self but for the man, in relationship to the phallus of the patriarchal order. In becoming the total object of man's fantasy, the woman

becomes the mystified Other, serving to secure the male point of view and his knowledge of truth (Rose, 1982).

Lacan's analysis of the contradictory constitution of femininity, which includes the definition of women as objects of desire without individuality, can be used to understand anorexic and bulimic women's conformity to social norms regarding feminine identity, such as the ideal body and weight. In addition to the recognition of the illusion of the self as whole, which originates in the mirror stage and in which feminine identity is founded (Rose, 1982; Robertson, 1992), understanding femininity must take into account sexuality and subjectivity as constituted in language. "The subject has to recognize that there is desire, or lack in the place of the Other, that there is no ultimate certainty of truth, and that the status of the phallus is a fraud [this is, for Lacan, the meaning of castration]" (Rose, 1982, p. 40). Freud's and Lacan's psychoanalytic theories have been useful to a feminist understanding of eating disorders also because, by showing the illusory and unconscious origins of feminine identity and subjectivity in general, the theory subverts both the notion of knowable objective truth and the liberal humanist version of subjectivity as innate, autonomous, homogeneous, and rational (Grosz, 1990, as cited in Malson, 1998). Lacan's emphasis on the role of language in the construction of the unconscious and subjectivity takes Freud's theory further toward recognizing the social dimension. In attempting to bridge the dichotomy between individual and society, Lacan elucidates the contradictory nature of femininity and its patriarchal roots in linguistic practices (Malson, 1998).

Deconstructing Femininity, Subjectivity, and the Body with Post-structuralists

Freud and especially Lacan destabilized gendered subjectivity, describing it as decentred, shifting, and based in a fantasy of wholeness. Their psychoanalytic theories foreshadow a post-structuralist version of subjectivity that is also multiple and dispersed (Malson, 1998). Post-structuralists have used Lacan's elucidation of negatively defined femininity – woman as the Other of identity – as a metaphor for difference, for deconstruction and subversion of the phallogentric notion of identity (Malson, 1997; Jagger, 1996 and Spivak, 1989, as cited in Malson, 1999, p. 149). While Freud's and Lacan's analyses of subjectivity, gender, and patriarchy have been useful to feminist understanding of eating disorders, post-structuralism provides a more adequate framework because it propels beyond Lacan's abstract notion of the Symbolic order towards the material dimension, encompassing wider socio-political and gender-specific relations (Gavey, 1989; Malson, 1998). The following subsections are a brief description of the post-structuralist approach, focusing on those key features that are relevant to feminist psychology of eating disorders.

As a mode of knowledge, feminist post-structuralism “uses post-structuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change” (Weedon, 1987, as cited in Gavey, 1989, pp. 460). The notion of discourse is central to post-structuralist theories. Although discourses are composed of linguistic signs (as in Lacan's Symbolic order), they also encompass ways of doing things, or social practices (Malson, 1997). Encompassing both language and social practices, discourses are defined as systems of statements organized around common meanings and values, produced over time in socio-

cultural settings, ways of knowing, institutional practices, and in subjective experiences (Hollway, 1989, as cited in Benveniste, LeCouteur, & Hepworth, 1999). The view of discourses, or language, as a constitutive and constituting inter-subjective reality, opposes the liberal humanist view of language as a transparent medium through which we can access an objective reality and speak about an absolute truth (Gavey, 1989; Potter & Wetherell, 1987, as cited in Malson, 1997; Malson, 1999; Malson & Usher, 1997). The post-structuralist approach thus shifts understanding away from discovering objective facts and toward a discourse analysis concerned with “disrupting and displacing dominant (oppressive) knowledges” (Gavey, 1989, p. 463) that are embedded in liberal humanist assumptions. Discourse analysis is therefore less concerned with change than with understanding how socio-culturally specific discourses construct people, their identities, subjective experiences, and practices, and also how these discursive constructions make up systems of power relations (Gavey, 1989; Hardin, 2003b; Malson, 1997). Nevertheless, the post-structuralist recognition of the role of socio-political context in the constitution of subjectivity implies that gendered identity is potentially changeable (Weedon, 1987, as cited in Gavey, 1989).

Subjectivity is defined by post-structuralists as encompassing identities, emotions, behaviours, and thoughts, both conscious and unconscious, including self-understanding and understanding one’s relationship to the world (Benveniste et al., 1999). Discourses constitute individual subjectivity by offering subject positions that individuals take up when addressing, when being addressed, and when experiencing, behaving, or thinking (Benveniste et al., 1999). By offering a limited range of possible subject positions, discourses both constrain and facilitate human agency; people are free only to the extent

that they can choose from among available subject positions, or discursive versions of reality. Discourses regulate subjects; as both repressive and productive sites of power, they produce norms and standards that allow justification of one's actions within a network of social relationships (Potter & Wetherell, 1987, as cited in Benveniste et al., 1999; Guilfoyle, 2001; Foucault, 1972, as cited in Malson, 1997; Walkerdine, 1986, as cited in Malson, 1997). Located in discourses, power is exercised throughout society where it operates jointly with knowledge through political strategies and mechanisms (Foucault, 1977, as cited in Malson & Ussher, 1997). Discourses are multiple, thus offering competing, often contradictory subject positions, or ways of giving meaning and relating to events, objects, and people (Hollway, 1984, as cited in Gavey, 1989; Weedon, 1987, as cited in Gavey, 1989). Dominant discourses hold the most epistemic authority or power because they appear "natural," their "common sense truth" appears impartial (Gavey, 1989).

The post-structuralist view of individual subjectivity as constituted in discourse – changing, multiple, discontinuous, and contradictory – challenges the dominant liberal humanist view of a unified, continuous, autonomous, and rational self and the associated notion of a human essence (Moulding, 2003). In contrast to the liberal humanist notion of a feminine essence that is located within an individual, feminist post-structuralists view feminine identity as produced via socio-cultural discourses that regulate the female body in multiple, often contradictory ways (Malson, 1997). A post-structuralist framework makes possible the exposition and analysis of complexities involved in the individual-society relationship as well as the contradictory aspects of identity and of subjective experience (Gavey, 1989; Hepworth, 1994; Malson, 1997).

Post-structuralist theory enables a view of eating disorders as produced within multiple and contradictory systems of significations and power relations – an idea that overlaps with the feminist notion of eating disorders as expressive of complex gender-political issues and dilemmas (Malson, 1997, p. 224). Whereas post-structuralist theories can be highly abstract, feminist perspectives emphasize the material bases of power, including specificities involved in social, economic, and cultural arrangements (Weedon, 1987, as cited in Gavey, 1989). Feminism and post-structuralism can thus complement each other by engaging in both discursive and material aspects of the anorexic or bulimic body, “exploring the ways in which discursively produced meaning leans on corporeality” (Malson, 1997, p. 231). By attending to both discursive and material dimensions, feminist post-structuralism challenges the gendered mind-body dualism that underlies Western notions of femininity, subjectivity, and the body, as well as mainstream theories of eating disorders. Feminist post-structuralism can therefore be useful in the examination of the gender dynamics that underlie socio-cultural arrangements and the dominant psycho-medical theories of eating disorders (Gavey, 1989).

Chapter 2: Deconstructing Eating Disorders

Overview

Feminist post-structuralists maintain that the contradictory constructions of femininity are a form of patriarchal oppression of women, and eating disorders represent an attempt to reconcile the contradictions. According to feminist post-structuralists, underlying the contradictory femininity is Western mind-body dualism (e.g., Lester, 1997; MacSween, 1993; Malson, 1998; Moulding, 2007). The dualism, which harks back to Plato and “forms part of the West’s Christian heritage” (Malson, 1999, p. 139), is embedded and deployed in popular discourses and psycho-medical institutions. The mind-body dualism is pervasive, functioning as a “*practical metaphysics*,” which makes it difficult to overcome (Bordo, 1993, as cited in Ferris, 2003, p. 14). The mind-body dualism underlies Western notions of subjectivity and the body and is profoundly gendered (Malson & Ussher, 1996a), producing normative constructions of masculinity and femininity (Malson, 1999). The duality is further expressed in Western binary notions, such as the nature-nurture debate and the individual-society dichotomy. Feminist post-structuralists (e.g., Burns, 2004; Malson, 1999; Malson & Ussher, 1996a) view gendered subjectivity as constituted via both discursive-textual and physical-material aspects of reality, which allows for an analysis of gender inequalities and power dynamics as embedded in the gendered mind-body dualism; whereas the mind is construed as the self, idealized and associated with masculine qualities of reason, discipline, autonomy, and control, the body is construed as other, devalued and associated with feminine qualities of emotionality, impulsivity, danger, lack of control, and

threatening the integrity of the mental self. Consequently, feminine identity is construed as false and alien, as the other of the idealized masculine identity.

This chapter is a review of the feminist post-structuralist research that deconstructs eating disorders as embedded in Western mind-body dualism. The first section describes contradictory discourses of femininity as reproduced in postmodern cultural dilemmas and expressed through female anorexic and bulimic bodies and subjectivities. The second section presents a feminist post-structuralist problematization of the psycho-medical model of eating disorders and their treatment.

Deconstructing Contradictory Discourses of Femininity

Feminist post-structuralists view anorexia and bulimia not as disorders located within individual women but as a discursively constituted “relational disordering” between self and other, thus shifting the focus away from the individual and toward “relational spaces” (Hoskins, 2002, p. 239). They view eating disorders as an attempt to resolve the central contradiction placed on female subjectivity, that is, the contradiction between Western constructions of bodily femininity and masculine identity (MacSween, 1993). Eating disorders express multiple meanings related to Western culture’s “complex sociopolitical issues and contemporary socio-cultural concerns about gender and gender power relationships” (Malson & Ussher, 1996a, p. 509). Feminist post-structuralists argue that an understanding of these disorders must take into account how women’s distress around their bodies and food is related to discourses of femininity, subjectivity, and embodiment as expressed in contemporary post-industrial culture and embedded in the gendered mind-body dualism (e.g., Hoskins, 2002; Malson, 1999). This section

describes some of the contradictory discourses of femininity that are analyzed in feminist post-structuralist literature on eating disorders.

Gendered discourses of control and excess.

Western mind-body dualism constructs the “feminine principle” hierarchically in relation to the “masculine principle.” The gendered mind-body discourse of the idealized disembodied subjectivity construes the feminized body as the other of the mental self, threatening its integrity. Femininity, construed as bodily desire, excessive and out of control, opposes masculinity, construed as mental will, rational and in control (Bordo, 1990, as cited in Moulding, 2007, p. 58). Throughout Western history, the female reproductive and menstruating body has been constituted “as a site and source of feminine excess” (Malson, 1997, p. 229), pathologized and associated with vulnerability, emotionality, sexuality, danger, and impulsivity (Malson, 1997; Malson & Ussher, 1996a). Figures of reproductive femininity portrayed as excessive “pervade a variety of academic, clinical and popular discourses” (Malson, 1997, p. 241). Similarly, the fat female body has been construed as “ugly, uncontrolled and gluttonous” (Malson, 1997, p. 230; see also Lester, 1997).

Rather than viewing eating disorders as located in individual minds and bodies, the disorders can be viewed as produced within a specific socio-historical context of popular body management practices related to controlling the body to preserve personal, or mental, integrity (Malson, 1999, p. 139). Feminist post-structuralists view female self- and body-practices in pursuit of thinness as related to the gendered construction of desire and control that is embedded in the mind-body dualism (MacSween, 1993; Malson, 1998;

Bordo, 1993, as cited in Moulding, 2007). Both “normal” women and women diagnosed with anorexia construe their control of food intake, body shape, and weight as a means to gain control over their lives (Chesters, 1994). Anorexia represents a physical and symbolic consolidation of the dualism (Malson & Ussher 1996a). As Malson (1997) puts it, “the material-discursive practice of self-starvation results in a literal dematerialization of the body” (p. 241); this is an achievement of mental control over feminine bodily desires and excesses (Lester, 1997).

Anorexia represents a rejection of a specific type of femininity, constituted negatively within the mind-body discourse as powerless, “constricting and suffocating” (Bordo, 1993, as cited in Moulding, 2006), and signified by the fatter female body of “the sexual woman” and “the mother” (Malson & Ussher, 1996a). Likewise, the anorexic symptom of amenorrhea can be analyzed as a refusal of negatively constituted femininity as symbolized by the menstruating body (Malson & Ussher, 1996a). This analysis opposes the common reductionist views of amenorrhea as an immature refusal of womanhood, or as an apolitical, biological matter located within the individual (Malson, 1997).

The thin anorexic body, which represents a rejection of a femininity construed as uncontrolled and excessive, may “paradoxically be construed as uncontrolled, as an excessive control” (Malson, 1997, p. 241; see also Ferris, 2003). Bordo (1990, as cited in Moulding, 2007) shows how the gendered contradictions involved in desire and control are reproduced in post-industrial society, in the contradictions involved in production and consumption that construct a “bulimic” personality style: consumers, who are overwhelmed with temptations, resist over-indulging and control their desires by

becoming producers. As Moulding (2007) further adds, gendered contradictions are embedded and reproduced in the consumer-marketing of idealized images of a controlled feminine body, toned and slim.

Discourses of absent feminine identity.

In addition to being read as a self-destruction – a rejection of negatively constituted femininity – anorexia can also be read as a simultaneous self-production – an attainment of idealized (dis-embodied) femininity (Malson & Ussher, 1997, p. 57). The paradox expresses an attempt to resolve contradictory femininity. Malson (1999) explores how the disappearing anorexic body signifies the production of an absent identity, or an “identity-put-under-erasure” (p. 137). The anorexic identity construed as “problematic, elusive... undecidable... absent presence” (p. 148), as deconstructed, is a product of not only gendered modern values but also of a gendered postmodern culture. Postmodernity, like the anorexic identity, is difficult to define; it does not replace modernity but rather questions, problematizes, and deconstructs the modern notion of independent and uniform identity, including feminine identity. Many postmodern and post-structuralist feminists have argued against a unified notion of the category of women, emphasizing instead the diversity of women and their experiences. It can therefore be said that identity itself, that of a woman and of women, is put-under-erasure. As Lacan puts it, “the woman does not exist” (Lacan 1982, as cited in Rose, 1982, p. 48). Defined only in relation to the phallus, her sexual identity is construed negatively “in terms of what ‘she’ is not, as Other, as not-I, not-One” (Benvenuto & Kennedy, 1986, as cited in Malson, 1999, p. 149).

As Malson and Ussher (1997) further argue, the negatively constituted feminine identity belongs also to the nurturing and self-sacrificing mother, whose existence has been negated by patriarchal cultures (Irigaray, 1988, as cited in Malson & Ussher, 1997). Consequently, the mother has no positive identity to give to her daughter. Viewed more positively, the only identity she can give to her daughter is an “elusive identity.” Anorexic simultaneous self-destruction and self-production can thus be analyzed as a point of identification between the daughter and her mother’s elusive identity. The elusive feminine identity has been reproduced, aestheticized, and romanticized in the deathly, disembodied, ethereal female figures of mythology and art (e.g., sirens, sorceresses, fairy creatures, deathly brides) (Malson & Ussher, 1997). Malson (1999) discusses how the postmodern consumer culture, particularly the fashion industry, has reproduced femininity as disappearing. In displacing especially the female sensate body with the body-as-image, consumer culture has produced anxieties about body-image and anorexic practices

Malson and Ussher (1997) observe that in addition to its negative constructions, the elusive, ethereal, deathly feminine identity can be read as an act of resisting and undermining the “disciplining, individualizing and gender-ing gaze” (p. 56). In line with this reading, the authors examine how the anorexic destruction of the embodied self can be read as a way of becoming less visible. The theme of being visible, or the gaze of the other, has been emphasized in popular culture and in both psychoanalytic and post-structuralist theories. Lacan highlights the role of visibility with his notion of the mirror stage. Visibility plays an important function also during the Oedipal stage of psychosexual development, in the entry into the (patriarchal) symbolic order of values;

the girl develops a feminine identity, when she *perceives* she lacks a penis. Similarly, in the post-structuralist theory, the gendered subject is constituted, revealed, and regulated within the “economy of visibility” (Foucault, 1977, as cited in Malson & Ussher, 1997, p. 57). Therefore, as Malson and Usher suggest, the anorexic attempt at self-destruction through becoming less visible can be read as a resistance to the oppressive patriarchal economy of visibility. Paradoxically, as the (anorexic) body becomes emaciated, it becomes more visible, more subjected to the scrutinizing gaze of the self and others, including health professionals, and to constant monitoring of food intake, body-shape, and weight.

Femininity and popular discourses of identity and body.

The post-structuralist notion of identity as “a constantly evolving process of creating self” (Hoskins, 2002, p. 238) clarifies how the complexity of postmodern consumer culture exacerbates girls’ struggles with developing self-identities – a struggle that eating disorders represent. According to Hoskins (2002), the developmental stage of experimenting with identities makes girls especially vulnerable to consumer-marketing of identities, which are construed as commodities to be purchased and explored. The marketed identities are communicated through symbols, images, and metaphors, and carry messages that are oftentimes contradictory, about strength and independence, vulnerability and passivity (Bordo, 1993, 1997 and Brumberg, 1988, 1997, as cited in Hoskins, 2002, p. 237). These messages contribute to the complexity of the identity development of girls, who have to decode, negotiate, and evaluate their meanings. The surface body-as-image, which consumerism equates with individual identity, is perfected

in accordance with the current fashion style (Malson, 1997, p. 145), and body image and shape can be purchased and transformed through genetic engineering, cosmetic surgery, and augmentations such as breast enhancement and liposuction (Hoskins, 2002). Further complicating girls' developing identities is the expansion of communication technologies, such as the existence of websites that recruit members and promote anorexia. Thus, what might begin as an experiment with thinness may up as a difficult to relinquish anorexic identity.

Overlapping with consumer messages of identity construed as body-as-image are media's increased portrayals of sexuality combined with unrealistically thin female body shapes that present a narrow range of beauty standards (Hoskins, 2002, p. 236). In an attempt to compensate for feelings of inadequacy, which the idealized media images produce, girls become preoccupied with their bodies, treating them as "personal improvement projects" (Hoskins, 2002, p. 234). The thin images appeal to girls because, embedded in the gendered mind-body discourse of disembodied subjectivity, they are "a visual code that speaks... about the [masculine] power of being aloof rather than desirous, cool rather than hot, blasé rather than passionate, and self-contained rather than needy" (Bordo, 1993, as cited in Hoskins, 2002, p. 234). Yet, as both Hoskins (2002) and Lester (1997) explain, the cultural meanings of the thin body oppose its psychological meanings, that is, the patriarchal notion of "what makes girls 'worthy'" (Hoskins, 2002, p. 235). The psychological meanings include: "conformity to sexual stereotypes, vanity, superficiality, a need for acceptance and approval, vulnerability, delicacy and fragility, and a desire to take up as little physical (read: social) space as possible or, in the anorexic's case, to disappear all together" (Lester, 1997, p. 487). Given the contradiction

between cultural and psychological meanings associated with the thin body, a pursuit of the thin ideal turns into an irreconcilable paradox that enslaves the anorexic girl or woman; her internal self-project is progressively replaced with obsessive practices related to the external body viewed as image (Lester, 1997).

Ferris (2003) provides an analysis of how popular media reproduces the normative discourse of the culturally “appropriate” thin female body. Both obese and anorexic body types are construed by the media as hyperfeminine, excessive, and positioned at the limits of cultural “intelligibility.” However, whereas the anorexic body is construed as in need of being saved and included in the cultural domain of intelligibility, the obese body is construed as trying to enter and conform to it, yet is continually denied that entry through such rhetorical tactics as criticism and social pressure. In reproducing the normative discourse of the culturally appropriate body, the “culture not only defines and contains women’s bodies, but it also defines how these [excessive or thin] bodies should respond” (p. 271), thereby limiting women’s agency. Effectively, many women and girls do not have the power to fully transgress the cultural boundaries that delimit the appropriate thin body. Along similar lines, Lester (1997) argues that “thinness in American culture is overdetermined and carries multiple significances. Women cannot simply make thinness mean whatever they want it to mean” (p. 487).

Femininity and popular discourses of health.

Feminist post-structuralists (e.g., Burns & Gavey, 2004; Hardin, 2003b; Moulding, 2007) argue that the popular construction of health is implicated in the

development of and recovery from eating disorders. Discourse analyses of accounts given by women and girls recovering from anorexia suggest that they are unable to avoid the societal preoccupation with health, which includes a narrowly defined “healthy weight,” body management practices of energy and weight regulation, and self-surveillance. Although intended to combat and prevent the problem of obesity, the public promotion of healthy weight serves to rationalize, encourage, and normalize such self- and body-practices as focusing one’s mental, physical, and emotional energy on oneself in the pursuit of the thin ideal. The healthy weight practices have been correlated with anorexic and bulimic behaviours of dieting, bingeing, purging, and self-monitoring.

A public focus on healthy weight, as opposed to health itself, overlaps with “the gendered slenderness imperative” (Burns & Gavey, 2004, p. 556) that is construed as a sign of success, control, and heterosexual attractiveness for women. The practices related to the discourse of healthy weight are therefore not gender-neutral but can be read as yet another form of patriarchal technology of femininity, contributing to the production of the slender body as the ideal female body, not only healthy but beautiful and heterosexually attractive, and therefore passive, objectified, and sexualized (Malson, 1997). Burns and Gavey (2004) argue that the healthy weight discourse objectifies women’s bodies and their body-practices by exposing them to the objectifying “gaze and scrutiny of an ever-increasing number of normalizing experts (i.e., nutritionists, personal trainers, weight loss groups)” (p. 560). The pursuit of healthy weight, which signifies control, and success, and heterosexual attractiveness, paradoxically may turn into unhealthy anorexic and bulimic practices of dieting, self-starvation, bingeing and purging – a rejection of the body and the specific type of femininity which it symbolizes: passive,

objectified, and sexualized (Malson, 1997).

Problematizing the Psycho-medical Discourse of Eating Disorders

For feminist post-structuralists, the existence of anorexia and bulimia as diagnostic categories indicates a male-dominant gender order (Robertson, 1992). As Malson (1997) observes, all bodies, are “always-already caught up in discourse, in systems of meaning, or symbolic representations and power relations” (p. 226), and no theory or methodology is gender-neutral or apolitical. The feminists have criticized traditional psycho-medical explanations of eating disorders for their apparent gender neutrality, viewing their lack of attention to gender issues as a strategy to maintain a political *status quo*, including their epistemic authority regarding objective knowledge and the culturally dominant, gendered mind-body dualism (Malson et al., 2004, p. 476). The following subsections present the feminist post-structuralist problematization of the psycho-medical discourse of eating disorders, their aetiology, and the treatment, including resistance.

Eating disorders as diagnostic categories.

Psycho-medical discourse contributes to the social control of female anorexic and bulimic bodies by reproducing the Western gendered mind-body dualism expressed in assumptions about objective knowledge and the liberal humanist model of a healthy self that is characterized by the masculine qualities of rationality, control, continuity, homogeneity, free agency, and individual responsibility (Burns, 2004; Eivors, Button, & Warner, 2003; Gremillion, 2002; Lester, 1997; Malson, 1997; Moulding, 2003). Based on

this model of self, psycho-medical discourse conceives psychological meanings associated with the anorexic or bulimic behaviours as a pathology related to personality traits and genetic factors, and conceptualizes the physical dimension of the disorders as a strictly biomedical issue, effectively disregarding the socio-cultural context (Malson, 1997, p. 223; see also Guilfoyle, 2001). Hardin (2003a) argues that diagnosing has the effect of reinforcing the diagnostic category, eating disordered behaviours, and healthcare providers' epistemic authority in objective knowledge. Feminist post-structuralists oppose the positivist assumption about objective reality and knowledge that underlies mainstream psycho-medical theories of eating disorders, and they emphasize the existence of eating disorders via what we know about them – as opposed to what they are – through the use of psychiatric terminology and particular subject positions that are offered to women by the psycho-medical discourse (Burns 2004; Guilfoyle, 2001; Hardin, 2003a; Hepworth, 1999). An understanding of eating disorders must therefore go beyond common notions of eating disorders as a deviance from the healthy norm, as a personal pathology, or due to family dysfunction and Western culture's preoccupation with dieting, body shape, and weight (Hoskins, 2002; Malson, 1999).

Based on a theorization of embodied subjectivity (Lester, 1997) and individual-society relationship (Malson, 1997), feminist post-structuralists explore: “multiple, often contradictory ways in which clinical diagnoses are constituted and experienced... the power-relations and normative cultural values imbricated in these discursive constructions; and... the meanings, values and politics that are re-produced in the discursive practices of treatment” (Malson et al., 2004, p. 476). Several feminist post-structuralist studies have examined the discursive construction of anorexia (e.g.,

Hepworth, 1994, 1999; Lester, 1997; Malson, 1997, 1998, 1999; Malson & Ussher, 1996a, 1996b; McVittie, Cavers, & Hepworth, 2005) and bulimia (Burns, 2004; Burns & Gavey, 2004; Guilfoyle, 2001) as diagnostic categories. Malson (1998) and Hepworth (1994, 1999) provide an analysis of the historical emergence of anorexia and bulimia as medical categories. Malson (1998) discusses how the feminization of mental illness, specifically hysteria, along with multiple and contradictory discourses of femininity rooted in the 19th century medical discourse of subjectivity, femininity, and embodiment, made possible the discovery and the feminization of anorexia. Hepworth (1994) discusses how the 19th century feminization of both nervous disease and anorexia has been an obstacle to recognizing anorexia's other causes and acknowledging that it is more common among males than is generally believed; males who present symptoms similar to those of females are more likely to be diagnosed with other illnesses and less likely to admit to having anorexia. A study by McVittie et al. (2005) shows that men and health professionals tend to view anorexia as a feminine disorder: using explicit references to femininity, they construe anorexia in males as a disorder of masculine identity, as a deviation from gender norms, describing these men as different from men in general and mentally weak; alternatively, they construe it as a symptom of depression. Effectively, gendered constructions of anorexia are reproduced, as are normative notions of invulnerable masculine identity and weak feminine identity.

Burns' (2004) discourse analysis shows that the gendered mind-body dualism underlies the psycho-medical discourse and produces dualistic and hierarchical constructions of anorexia and bulimia. Anorexic identity and practices are construed as privileged and associated positively with control, moral strength, and discipline, which

are exercised over the body and its urges. Conversely, bulimia is construed negatively as a categorically devalued eating disorder, as the “other” of anorexia; bulimic identity is associated with a lack of moral strength, discipline, and control over the body, and bulimic bingeing and purging are construed as incongruent, impacting negatively on the understanding of and treatment provided to females with bulimia.

Psycho-medical treatment and prevention of eating disorders.

Most research on the treatment of eating disorders has focused on outcomes. The conflicting and inconsistent findings regarding the recovery rates have been related to inconsistencies in: outcome criteria, how recovery is defined, lengths of follow-up, and research methodologies used. Studies with more stringent recovery criteria reveal fewer fully recovered cases and healthcare workers’ negative attitudes toward patients (Malson et al., 2004), suggesting poor treatment efficacy (Hardin, 2003b). The few studies so far conducted reveal that patients report relatively low levels of satisfaction with treatment experiences (e.g., Eivors et al., 2003; Gremillion, 2002; Guilfoyle, 2001; Malson et al., 2004), which suggests a need for improved treatment and therapy (e.g., Guilfoyle, 2001; Malson, et al., 2004; Surgenor et al., 2003). According to feminist post-structuralists, the results indicate a need for more research addressing patients’ accounts of treatment and patient-therapist power dynamics (e.g., Burns, 2004; Hepworth 1999; Guilfoyle, 2001; Malson et al., 2004; Surgenor, Plumridge, & Horn, 2003). Feminist post-structuralists (e.g., Gremillion, 2002) regard the mainstream treatments’ narrow focus on food, eating, and weight as reinforcing anorexic and bulimic pre-occupations and practices.

Eivors et al. (2003) note that, due to the unequal power dynamic between patients

and healthcare workers, treatment may re-invoke patients' feelings of powerlessness, which anorexic and bulimic practices may have served to alleviate, thus ironically contributing to the maintenance of dysfunctional behaviours. According to feminist post-structuralists (e.g., Gremillion, 2002; MacSween, 1993; Malson, 1998; Moulding & Hepworth, 2001), the unequal power dynamic is embedded in the gendered mind-body dualism. Hepworth's (1999) and Moulding's (2003) discourse analyses revealed the mind-body dualism as underlying the healthcare workers' tendency to assume a parental role towards the female patients, to construe them as emotional and overly dependent on others, their eating disorders as a way of dealing with an incomplete sense of self, and their dysfunctional control as a way to preserve agency. Malson et al. (2004) found the mind-body discourse deployed in healthcare workers' objectifying and pathologizing constructions of patients. Patients were found to view such explanations as unacceptable and incomplete, construing their eating disorders as only a part of their identity. Compared to the reports given by health care workers, patients' accounts of treatment and diagnosis experiences are more elaborate, personalized, empowered, and involve multiple and often contradictory discourses (Malson, et al., 2004).

Moulding and Hepworth's (2001) research at a community-based eating disorder prevention centre examined the gendered mind-body discourse deployed in healthcare workers' emphasis on a didactic approach, individual responsibility, and control over the body and abnormal emotions. The exclusion of participants from managing and administering prevention programs is entrenched in individual-society dualism, which is embedded in the mind-body discourse. The exclusion reproduces the dichotomy between true-objective knowledge, in terms of healthcare workers' epistemic expertise and

authority, and the false-subjective knowledge of the participants, effectively reinforcing the unequal power dynamic between the healthcare workers and the program participants. Similarly, Moulding (2007) found a marketing framework of a body-image health promotion program to be embedded in contradictions of individual-society/mind-body dualities. On the one hand, the marketing framework construes the participants as passive consumers. On the other hand, the marketing of self-care promotes the discourse of individual responsibility (i.e., for one's personal health and autonomy from the social pressure to be thin), thus construing the participants as active. The discourse of self-care idealizes the masculine control by promoting the idea of regulating the feminine body and its desires.

Redefining resistance, prevention, and treatment.

Feminist post-structuralists regard treatment resistance expressed by female patients diagnosed with anorexia and bulimia as an exercise of power, as a protest against being defined in psychological terms (e.g., Guilfoyle 2001; Malson et al., 2004). According to Guilfoyle (2001), healthcare workers employ psychological terminology because it enables them to construe resistance as a part of patients' pathology, thereby allowing them to disqualify it. Healthcare workers disqualify resistance to eliminate the possibility of different subject positions for patients, which would threaten the healthcare workers' privileged position as epistemic authorities of objective knowledge and disturb the power dynamic in the patient-healthcare relationship. Guilfoyle (2001) maintains that further complicating and undermining resistance is a widespread popularization of psychological terminology, which has infiltrated Western lay notions of the person,

effectively producing “psychological subjectivities.” Nevertheless, eliminating the psychological discourse from therapy and substituting it with an exclusively feminist approach would be misguided, because only the local level of psychological discourse would be subverted; in the meantime, the psychological aspects of eating disorders would be left to the expertise of psychologists and psychiatrists, leaving unchallenged a more global problem of power. Drawing on Swann (1999, as cited in Guilfoyle, 2001), Guilfoyle emphasizes “the political, rather than psychological nature of resistance” (p. 173) and points out that psychotherapy can “effectively address [only] the psychological products of its oppression [self-blame and unworthiness]” (pp. 169-170). Accordingly, Guilfoyle argues for eating disorder treatments that combine the feminist approach with psychotherapy.

Giving a participant a voice, attending to her self-knowledge, including her refusal and subversion of clinical knowledge, can empower her. It can also expose the complexities of treatment or prevention and thus contribute to their authenticity (Malson et al., 2004; Surgenor et al., 2003). Understanding the patient and what the symptoms mean to her can enable the patient to define her identity separate from her eating disordered behaviours (Gremillion, 2002, p. 104). Yet, since patients’ accounts, or self-constructions, are not objectively true, it is important to remember that the scenario of attending to patients’ own perspectives is not equivalent to “patient-centred” treatment (Malson et al., 2004).

Moulding (2007) argues that adopting the consumerist framework in prevention programs, whereby mainstream social marketing strategies are employed, reduces the transformative potential of such programs. According to Moulding, in order for health

promotion programs to be responsive to the possibility of participants' resistance, transformative for the individual women with body-image problems, while at the same time changing the social factors implicated in eating disorders, the programs' decision-making process needs to involve not just "experts" in health and marketing but also the community. According to Hoskins (2002), a treatment approach based on a didactic idea of transmitting information to an audience forced into passivity is inappropriate for eating disorders, which represent problems in "relational spaces." Hoskins suggests a more egalitarian dialogue that employs a creative exploration of women's personal experiences (e.g., through literary metaphors and visual mapping of relationships), arguing that this might give women an opportunity to explore the process of discursive meaning-making and to construct new ways of relating to oneself and to others. Writing might encourage change, support a new self-identity, and strengthen one's sense of self in relation to discourses and the skills necessary to navigate the complexity of postmodern life. In addition to verbal exchanges and exploration through visual means, Burns (2006) explores the notion of "embodied reflexivity" as deployed in dialogues between research interviewers and respondents, which could also apply to dialogues between healthcare workers and patients. Burns describes "embodied reflexivity" as going beyond the level of language and focusing on embodied reactions and responses. Based on the idea of material discourses, specifically, Burns develops the idea that interactions between embodied subjectivities involve a "mutual and continuous (re)construction" (p. 8) of bodies and body-images.

Chapter 3: Feminist Art Therapy

Overview

This chapter presents a review of feminist art therapy literature, toward a working model for art therapy that integrates feminism and post-structuralism in the area of eating disorders. Addressed in this chapter are feminist art therapists' views on: obstacles to feminist and art therapy research and publishing; patriarchal approaches to theorizing and conducting research; implications of feminist perspectives for art therapy practice, including understanding and working with images and symbolic representation, and the notion of embodied image-making.

Gender Bias in Art Therapy Research and Publication

A shift in an art therapist's theoretical perspective will affect his or her attitude and practice (Hogan, 1997b). A feminist perspective is especially relevant to art therapy as more than ninety percent of its practitioners are women (Joyce, 1997). Ironically, the number of feminist art therapy peer-reviewed publications is relatively small compared to other professions, and no of the publications are devoted exclusively to the subject of eating disorders. This does not mean that there are no feminist art therapists, as exemplified by two collections of contributions from feminist art therapists, both edited by Hogan (1997a, 2003a).

One of the reasons for the shortage of feminist art therapy peer-reviewed publications is the relative novelty of feminist perspectives in research and publication, historically a male domain (Talbot-Green, 1989). The main reason, however, is gender

bias in clinical theory, editorial policies, research, and professionalism (e.g., Burt, 1996, 1997; Joyce, 1997; Talbott-Green, 1989; Wadeson, 1997), which feminist art therapists (e.g., Joyce 1997; Talbott-Green, 1989; Vellet, 2004) have attributed to the inability of individual researchers and therapists to integrate repressed feminine aspects of their psyches. Joyce (1997) and Talbott-Green (1989) explore how the gender bias in the hierarchy of mental health expertise prevents art-therapists from becoming fully professional and published: art therapists, who are predominantly female, have extensive interactions with clients, yet it is psychiatrists and psychologists, who are predominantly male, who hold the status of mental health experts, who diagnose, assess, and publish most, thereby reproducing patriarchal, positivist notions about mental health and illness (Joyce, 1997).

Critique of Patriarchal Approaches to Research and Theorizing

Art therapists who conduct feminist research and expose gendered realities seek to reveal patriarchal dominance within the gender power differential (Burt, 1996; Davis Halifax, 2003). They view “personal as political,” which in critical theory means “the interrelationship between personal, individual experiences and legislative and political structures” (Fabre-Lewin, 1997, p. 115; see also Burt, 1997; Davis Halifax, 2003). The gender bias in research and publishing favours a masculine cognitive style, characterized by mastery through control, manipulation, separation, and ego enhancement, and a moral ethic based on rights and privileges; women’s cognitive style, which is based on values that include caring (Carlson, 1972, as cited in Talbott-Green, 1989), participation, and cooperation, is viewed as inferior (Gilligan, 1982, as cited in Talbott-Green, 1989).

“Cooperative direct engagement” with research participants is the methodology of choice among contemporary feminist researchers (Talbot- Green, 1989, p. 258). Feminist art therapists argue against the dominant patriarchal discourse (Davis Halifax, 2003) that produces theories based on generalized and oversimplified interpretations of women’s experiences; instead, they highlight the need for researchers to take into account multiple perspectives, the context, and the diversity of women’s subjective experiences (e.g., Burt, 1996; Davis Halifax, 2003; Talbot-Green, 1989; Wadeson, 1997), including “perceptions, emotions, interactions, and values” (Talbot- Green, 1989, p. 288), and such differential facets as race, sexual orientation, ability, age, and ethnicity (Davis Halifax, 2003). Art therapists (e.g., Hogan, 1997b, 2003b) who adopt a feminist postmodern methodology attend to the process of constructing meaning and knowledge, focusing on who is asking whom what types of questions, while critically examining patriarchal assumptions about mental health and theories of human development.

Gender as a Social Construction

Feminist art therapists (e.g., Davis Halifax, 2003; Loureiro De Oliveira, 2003; Joyce, 1997; Hogan, 1997b, 2003b) share the view of gender as socially constructed rather than innate. Hogan (2003b), who integrates postmodern theory with feminism, points out that viewing gender as a social construction encourages an exploration of oppressive socio-political effects associated with normative meanings ascribed to femininity. Viewing gender differences as “natural,” or biologically determined, is used to justify gendered norms and regulatory practices. Hogan argues that, because we cannot step outside culture but can only be critical of it, the biological view of gender

differences, a view that presumes an objective understanding of nature, is invalid. Hogan (1997b, 2003b) describes normative meanings associated with masculinity and femininity as not only culturally determined but also as constantly reconstructed in multiple ways through institutional norms, practices, and representations, both verbal and visual; the gendered “‘I’ can be understood as a complicated field of competing subjectivities and competing identities” (Moore, 1994, as cited in Hogan, 2003b, p. 19), “fragmented, unstable... in constant state of flux and reconstruction” (p. 20). Feminist art therapists who examine lesbian, gay, and transsexual issues (e.g., Addison, 2003; Loureiro De Oliveira, 2003; Fraser & Waldman, 2003) challenge naturalistic normative notions of heterosexual femininity, drawing attention to its inherently social construction according to the phallogentric hierarchy, within which women are construed as sexual objects and ascribed a lesser value than men, who are construed as sexual subjects.

Gender Bias in Psycho-medical Theories

Feminist art therapists argue against interpretations based on “reductive and universally applied dogmatic psychological modes that do not sufficiently address the socially constructed nature of individual distress” (Hogan, 2003b, p. 12). Viewing normative constructions of gender difference as “central to representational systems of social organization” (Hogan, 1997b; see also Slater, 2003; Vellet, 2004), “with representations of gender articulating rules of social relationships” (Hogan, 1997b, p. 42), they emphasize the need to examine clients’ subjective experiences of health, illness, and treatment in the context of gender-biased psycho-medical institutions and assumptions about mental health and illness (e.g., Loureiro De Oliveira, 2003; Hogan, 1997b, 2003b).

The *DSM-IV* is often regarded by therapists as a source of objective truth. By failing to acknowledge the gender bias that is entrenched in the *DSM-IV* – the original version having been created exclusively by men (Burt, 1997, p. 101) – art therapists risk obscuring clients' crises with preconceived notions of gender (Hogan, 2003b) and disregarding their needs and the value of the art therapy process (Burt, 1997). This can also happen when art therapists are uncritical of *DSM*-based art therapy assessment tools, such as the *Diagnostic Drawing Series (DDS)* that is used to assess clients for major psychiatric disorders, including eating disorders (Burt, 1997). The *DSM* is based on traditional theories, including those of Freud, Erickson, and Bowlby, which define human development through the traditionally male attributes of autonomy and independence, as a movement toward a separate self. In contrast to the popular criteria used to define healthy men, the criteria used to define healthy women include: less independence, more emotionality, more sensitivity, and more preoccupation with appearance (Burt, 1997). Similar criteria are used to diagnose "borderline personality disorder," namely, "dependency, emotionality, fear of being alone" (Burt, 1997, p. 101). The vast majority of those diagnosed with borderline disorder are women (APA, 1994, as cited in Burt, 1997; see also Wadeson, 1997), yet the childhood history of sexual abuse that is commonly found among them remains largely unacknowledged (Burt, 1997, p. 104).

Many developmental theories construe female adolescence as a time of confusion and self-destruction; however, feminists acknowledge that this stage can also be read as a time of exercising resistance, and hence as a sign of courage and strength rather than pathology (Joyce, 1997). The view of women as prone to illness is exacerbated by the matricentric research that construes mothers as solely responsible for their children's

wellness, illness, and development (Burt, 1996, 1997), based on Freud's notion of the mother as a prototype for all later love relationships (Freud, 1949, as cited in Burt, 1996, p. 26) and extended by Bowlby in his theories of relationship attachment. These developmental theories focus on pathology without regard for socio-political problems, locating illness within sick individuals, especially women, who are construed as inferior to men, as prone to illness, as objects of clinical gaze (e.g., Burt, 1997; Hogan, 1997b, 2003b; Joyce, 1997). According to feminists, the misconstruction of women's suffering as illness, when in fact women's oppression is a main source of their "dis-ease," is a form of institutionalized oppression, a political strategy to control and exclude women, and to exploit their subservience to maintain the political *status quo* (Fabre-Lewin, 1997; see also, Joyce, 1997).

Wellness through Empowerment

The psycho-medial pathology perspective focuses on looking for and treating symptoms of illness and making interpretations, based on universally applied, reductive theories that, for example, construe women's problems as entirely rooted in early childhood experiences, to the exclusion of the here-and-now, including socio-economic and political context (Hogan, 1997b, p. 38; see also Burt, 1997; Davis Halifax, 2003; Fabre-Lewin, 1997; Hogan, 2003b; Wadeson, 1997). Feminist art therapists oppose the pathology perspective and emphasize wellness, strength, and empowerment (e.g., Davis Halifax, 2003; Hogan, 1997b, 2003b; Joyce, 1997; Öster, Magnusson, & Thyme, 2007; Talbott-Green, 1989; Vellet, 2004; Wadeson, 1997) through "creativity, personal growth, innovative problem-solving, divergent thinking, flexibility, spontaneity, self-

esteem, self-actualization, and personality integration” (Talbot- Green, 1989, p. 259). Feminist art therapists assist women in becoming aware of how their personal circumstances are socially constructed and how they fit into the collective gender power struggle, viewing this as enabling women to validate and express denied aspects of themselves, including their needs and emotions, especially anger, which they tend to repress through “selfless, caring or nurturing behaviours” (Ross, 1997, p. 141; see also Wadson, 1997). In the process, their dominant representations are challenged and a new identity and a sense of self-determination are supported (e.g., Hogan, 1997b; Ross, 1997; Vellet, 2004).

Unlike in traditional dynamic psychotherapy, where the “neutral” and “objective” psychotherapist (Burt, 1997, p. 98) is superior to the patient (Rowe, 1993, as cited in Hogan, 1997b, p. 38), feminist art therapists (Fabre-Lewin, 1997) seek to minimize the therapist-client power differential by becoming “cultural activists” who empower female clients by enabling them to confront and deal with the effects of patriarchy and by treating them as their own experts. Women are encouraged to actively participate in their therapeutic process, in setting goals and evaluating their progress, in choosing the therapist, therapy location, and how to represent themselves and the mode of representation used (e.g., Burt, 1997; Davis Halifax, 2003; Fabre-Lewin, 1997; Hogan, 1997b, 2003b; Joyce, 1997; Liebmann, 1997; Wadson, 1997). The power distribution in the client-therapist relationship is further shifted toward equality through creative dialogues facilitated by image-making (Ellis, 1989, as cited in Fabre-Lewin, 1997).

Fabre-Lewin (1997) considers images as the primary mode of expression and exploration of unconscious issues, and of relating to self and others, including

transferential feelings between client and therapist (p. 115). The emphasis on relatedness and engagement in working with images enables “clients to really experience themselves as artists, as creators” (p. 44). By “making the unspeakable visible to [the therapist who acts as] a supportive witness” (Burt, 1997, p. 98), clients experience validation (Wadson, 1997). “The supportive, collaborative, empowered, therapeutic relationship” (Davis Halifax, 2003, p. 35) may inform the client’s relationship with self and with others outside the therapy context.

Feminist art therapy contributes to clients’ empowerment and change by extending the focus of therapy to enhance and develop their strengths and life-management skills (Davis Halifax, 2003). An example of clients’ empowerment is given by Liebmann’s (1997), who describes an art therapy group run by women who live in an economically deprived urban area and who develop therapy rules and themes. According to the feminist post-structuralists, Öster et al. (2007), art therapy that involves an assessment of available socio-cultural resources and encourages women to “defin[e] boundaries against other people’s demands [and] establish... limits for one’s own space” (p. 287) can improve clients’ socialization, coping, and conflict resolution skills. Joyce (1997) adds to this list: assertiveness, employment training, and economic independence (p. 9).

Image-making and Symbolic Representation

Feminist art therapists such as Davis Halifax (2003) try to recognize the extent to which art therapists’ and clients’ perceptions of art’s moral, socio-political, and gender dimensions have been obscured by the patriarchal notions that characterize modern art,

such as an emphasis on artist's individuality and the view of artwork as a finished product with non-relational timelessness, universality, and radical originality (Gablik, 1993, 1995, as cited in Davis Halifax, 2003, p. 31). Davis Halifax calls for a need to recognize art-making as a socially involved, collaborative, and participatory process of creating meaning, of attempting to make visible "commonality, variety and difference" (Kaschak, 1992, as cited in Davis Halifax, 2003, p. 39) across "multiple levels and contexts" (Davis Halifax, 2003, p. 39). Hogan (1997b) adopts a postmodern notion of multiplicity of overt and repressed meanings, which allows for the recognition of multiple sources of construction: the woman artist herself, the viewer or the therapist, and all other visual representations of women, socio-cultural norms and beliefs as found in Western art, literature, medicine, and psychology.

The external oppression of women is represented through both language and visual images; once internalized, it establishes women's role as victims (e.g., Davis Halifax, 2003; Fabre-Lewin, 1997; Ross, 1997; Vellet, 2004). Consequently, the therapeutic process of expression and exploration through images and words can help women understand their victim position within the collective context (Vellet, 2004). Vellet discusses how the internalized collective power struggle manifests itself in a split identity in men and women: feminine identity, associated with passivity and submission, supports the victim position, whereas masculine identity, associated with activity and aggression, supports the split-off victimizer or abuser.

Incorporating Schaverien's (1992, as cited in Vellet, 2004) notion of "image as scapegoat," as a safe place where disowned, "split-off," "bad" parts of the psyche are projected, Vellet (2004) suggests that the created image can be viewed as representing the

split-off feminine element construed as a devalued victim, and also as “a personal and cultural splitting and disconnection between spirituality and sexuality within intimate relationships” (p. 19). From this perspective, a woman who creates an image takes on the masculine role construed as the active and aggressive abuser, or victimizer, with the therapist as a carrier “of the projective identification of past rejecting scapegoaters” (Schaverien, 1992, as cited in Vellet, 2004, p. 18). Similarly, Hogan (1997b) maintains that the woman artist experiences a contradictory tension by taking on the traditionally active masculine role of the subject, or the viewer of the image. The image, in turn, signifies her traditional passive role as an object being viewed (Pollock, 1988, as cited in Hogan, 1997b, p. 31). The creative process of making and dialoguing with images can therefore bring about a greater awareness of painful feelings associated with the feminine, scapegoated identity and its eventual reconciliation with masculine elements, on both collective and personal levels; symbols of integration include hermaphrodite and androgen figures (Vellet, 2004). Yet, as Hogan (1997b) warns, remaining in the realm of the symbolic features of images might serve only as a palliative; art therapy needs to effect change not only at the collective, personal levels of its female clients, but also at their bodily levels.

Embodied Image-making

Women’s oppression impacts their bodies in a profound way; for example, women’ subservient positions combined with representations of objectified female bodies and idealized thinness, lead women to develop an ambivalent, and in some cases an estranged relationship with their bodies, feelings, and desires (Orbach, 1991, as cited in

Ross, 1997; see also Fabre-Lewin, 1997; Hogan, 1997b). One of the ways this alienated relationship manifests itself is through eating disorders: the body becomes a battleground for issues of boundaries and control in reaction to feelings of lack of control over external circumstances (Ross, 1997; see also Hogan, 1997b, 2003b). As one experiences the world and oneself in and through one's body, the body becomes a site of socio-political domination and resistance (Fabre-Lewin, 1997; Hogan, 2003b).

The embodied, physical engagement with art materials during image-making goes beyond the symbolic, enabling women to reconnect with their bodies (Fabre-Lewin, 1997). By becoming more conscious of the relationship between their bodies and the world, women gain a greater awareness of themselves and of the impact of external forces on their bodies (Fabre-Lewin, 1997, p. 119). Feminist art therapists (e.g., Fabre-Lewin, 1997; Vellet, 2004) suggest that the integration of mind and body through the combination of conscious and embodied aspects of image-making provides an effective avenue for a cultural and political change. According to Fabre-Lewin (1997), the embodied aspect of image-making also accounts for a greater effectiveness of art therapy as compared to verbal therapies, whose focus on mental processes, such as "verbal recollection to enable a catharsis of unconscious conflicts" (p. 118), construes the role of the body as passive. The active involvement of the body during art therapy induces a greater psychic investment, depth of feeling and thought, transcending what is known at the conscious level and not readily amendable to verbal discourse (Schaverien, 1992, as cited in Vellet, 2004), such as difficult body experiences (Malchiodi, 1997, as cited in Öster et al., 2007). Martin's (2003) use of video and photography with older women shows how the body can be used to explore and challenge normative constructions of an

aging female body. Fabre-Lewin maintains that the embodied process of image-making contributes to a revised identity by giving women a space and the opportunity “to make their mark, release painful emotions, exercise their imaginations” (pp. 121-122), to make visible and document the unspeakable, all of which can be witnessed and validated by the woman artist and the art therapist (Burt, 1997). “In art therapy the sheet of paper can be seen as the territory within which the woman-as-client takes total control” (Fabre-Lewin, 1997, p. 122), and where the creative act “reinforces her awareness of her power to create and give shape to herself and her life” (Ellis, 1989, as cited in Fabre-Lewin, 1997, p. 122), thus reducing institutionalized and internalized oppression.

Chapter 4: Postmodern Art Therapy

Overview

This chapter presents a review of postmodern art therapy literature, focusing on concerns that are consistent with those found in post-structuralism: a critique of the psycho-medical pathology perspective; an emphasis on empowerment and wellness; reconstructing meaning through creative process; theorizing the therapeutic relationship; and working with the social and communal aspects of reality.

Postmodernism and Post-structuralism

At the time of writing this paper, no art therapy publications that integrate feminist and post-structuralist perspectives could be found, with the exception of Öster et al. (2007) who employ discourse analysis and draw on gender theories. Several art therapy authors do integrate postmodern perspectives. Although post-structuralism is not synonymous with postmodernism, as theoretical perspectives they share several basic concerns and assumptions that oppose modern notions. They oppose the modern notion of self as an autonomous, homogenous, and natural entity. Instead, they view the self as a socially construed fiction. They oppose singularity and objectivity of truth, an essentialist and naturalist view of meaning, teleological doctrine and reductive causality. Instead, they emphasize plurality of meaning and its social construction through relationships, thus challenging dichotomous notions, such as “external” and “internal,” “mind” and “body,” “male” and “female.” They are critical of purely analytical approaches to therapy, instead endorsing pragmatism and process (Byrne, 1995).

Critique of the Pathology Perspective

Most art therapists continue to rely on psychodynamic approaches. Postmodern art therapists (e.g., Alter-Muri, 1998; Henley, 2004; see also Spaniol, 2000) are critical of these approaches, arguing that they are rooted in the psycho-medical model that is informed by positivist theories which presuppose universal and objective “truths.” Theories that tell only one story, or truth, (Alter-Muri, 2007; see also Alter-Muri, 1998; Kapitan & Newhouse, 2000), “construct a closed system in which other, or the excess, is pushed to margins and made to disappear in the interest of coherence and unity” (Flax, 1990, as cited in Henley, 2004, p. 86). Along the same lines, Byrne (1995) describes pathology as a social construction that is “distorted by repression, censorship, excommunication, splitting-off aspects of the self” (p. 237).

When used in art therapy, psycho-medical theories produce reductionist notions about symbolic imagery that focus on signs of pathology, psychological conflicts, defence mechanisms, and their root causes, leading to assumptions about what is best for clients to diminish symptoms (Alter-Muri, 2007; Spaniol, 2000). According to Henley (2004), such psycho-medically based interpretations interfere with clients’ creativity, meaning-making, and therapeutic progress; they generate in clients feelings of being patronized and pathologized, giving rise to defensive and stereotyped imagery, and formulaic, clichéd verbal responses based on what clients have learned the therapist wants to hear.

Toward a Wellness and Empowerment Perspective

Postmodernists view meaning as not objective or innate, but construed through both linguistic and material discourses (Byrne, 1995; see also Alter-Muri, 2007). Meaning, including the meaning of images, is irreducible to spoken or written language (Alter-Muri, 1998, 2007; Henley, 2004); meaning is constantly changing, multiple, elusive, ambiguous, fragmented, and paradoxical (Henley, 2004; see also Hogan, 1997b, 2003b). Thus, the meaning of an artwork is irreducible to verbal interpretations; the client's personal and cultural aspects, which get articulated in the form and content of artwork, remain neither integrated nor homogenized, existing on their own terms according to their own undecipherable and unique logic (Henley, 2004, p. 86). Effectively, the role of postmodern art therapists is no longer to interpret clients' images using fixed meanings that focus on illness (Alter-Muri, 2007, Byrne, 1995; Henley, 2004). Instead, the therapist shifts the focus toward practicing wellness, toward psychological growth (e.g., Byrne, 1995; Spaniol, 2000) and empowerment (Alter-Muri, 2007). This shift includes giving clients an opportunity to tell their own stories about themselves and their images (Alter-Muri, 2007; see also Alter-Muri, 1998; Kapitan & Newhouse, 2000) and identifying the goals of therapy "in terms of the clients' wishes and desires" (Byrne, 1995, p. 236). Clients' personal metaphors are seen as particularly useful because they provide multiple references and entry points into their stories (Alter-Muri, 2007, p. 84), validating their narratives and legitimatizing their versions of truth (Grentz, 1996, as cited in Kapitan & Newhouse, 2000).

Henley (2004) draws on the idea that motivation and artistic "intentionality" are integral to the creative process. He suggests a non-pathologizing way of working with

clients' images that is based on an integration of studio and therapy approaches to responding to art: a studio-based critical approach to address formal aesthetic elements and clients' artistic skill, and a therapy-based empathically supportive approach to accommodate personal elements that might include highly vulnerable feelings. Employing psychoanalytic theory, Henley defines art as "a by-product of instinctual discharge [of self-stimulation, self-regulation, and self-comforting]...rooted in primary process and id derivatives" (Henley, 1989, as cited in Henley, 2004, p. 81). By responding to form and content, the therapist helps the client to "identify how the art can be used as a point of departure for future artistic explorations so the client has a sense of direction in which to launch new initiatives" (p. 81), thereby promoting psychological growth. To support his approach, Henley refers to Kramer's (1971, 2001, as cited in Henley, 2004) formal criteria (i.e., "evocative feeling," "inner consistency," and "economy of means") to evaluate the quality of artistic expression, based on Kramer's belief about a "fully formed expression" as a sign of a successful sublimation of unconscious conflicts.

Spaniol (2000) compares the postmodern emphasis on wellness, psychological growth, and recognition of clients' personal perspectives to the recovery model. The recovery model, which "refers to the consequences of the illness rather than its symptoms, and focuses on human potential rather than disease" (p. 79), calls for the need to get to know clients' unique qualities, contradictions, and experiences, while emphasizing their resilience. They further support clients' psychological growth and empowerment through such practices as an open door policy and by inviting them to participate in their own treatment planning and evaluation.

Therapeutic Process of Reconstructing Meaning

Alter-Muri (2007) views postmodern art therapists as witnesses and mentors who guide clients to examine personal narratives in relation to clients' unique experiences. By guiding clients' through a continuous process of "deconstruction and reconstruction" of meaning (Alter-Muri, 2007, p. 84; see also Alter-Muri, 1998), therapists enable clients to use their creativity and personal narratives to confront resistance and to develop trust, which strengthens the therapeutic alliance (Alter-Muri, 2007) and improves clients' "self-descriptions," toward psychological growth (Byrne, 1995, p. 236).

The postmodern idea of meaning as construed within relationships, constantly transforming and evolving, implies the need for the therapist to guide clients to trust the creative process rather than to impose reductive interpretations (Alter-Muri, 2007; see also Kapitan & Newhouse, 2000). According to Kapitan and Newhouse (2000), trusting the creative process to guide therapeutic change involves faith in the ability of the unconscious to transform meaning by organizing what at times might appear as a chaotic influx of thoughts, perceptions, and sensations. This requires the relinquishing of preconceptions, remaining open to the unknown, and acknowledging and tolerating paradoxes that might arise. Kapitan and Newhouse describe the self-organizing unconscious as a fluid structure "that frames the [art]work without distancing or disconnecting from it" (p. 115). Through its emphasis on the relativity of meaning, the postmodern approach frames art therapy as a process of recognizing and establishing relationships, rather than as an analysis of discrete parts. This approach relies on an intuitive attunement to "patterns of movements and relationships, and... on qualities like rhythm, flow, direction, and space" (p. 115), allowing forms to appear and then

disappear.

In contrast to the modern notion of a self-narrative that presupposes events as experienced on a linear timeline (e.g., Alter-Muri, 2007; Byrne, 1995; Kapitan & Newhouse, 2000), postmodernists view storytelling as continually reconstructed and redirected based on the notion of identity as changing, fragmented, contradictory, multiple, and devoid of essence (Gergen, 1991, as cited in Kapitan & Newhouse, 2000). According to Alter-Muri (2007; see also Alter-Muri, 1998), people arrange their experiences not only according to a linear timeline of events but also “as simultaneously presented pictures or compounded ‘scenes’ ... created from a pastiche of competing traditions” (p. 113).

Client-Therapist Relationship

The postmodern view of meaning as shaped by context (Alter-Muri, 1998), discursively construed and reconstructed within relationships, inter-subjectively and between matter (Kapitan & Newhouse, 2000, p. 115), has led art therapists to regard the client-therapist relationship as involving a collaborative meaning-making (Alter-Muri, 1998; Spaniol, 2000). Dialogues are conceptualized, not as a series of exchanges, but as a shared reality between the viewer-therapist, the artist-client, and the artwork (Alter-Muri, 1998). For example, in viewing a client’s artwork, the art therapist continues to give meaning to it, “extend[ing] the creative process began by the artist” (Alter-Muri, 2007, p. 83; see also Alter-Muri, 1998).

The therapeutic function of the non-verbal aspect of communication between a client and a therapist is recognized by Leclerc (2006), who writes about the importance of

the therapist's openness to unconscious forms of communication between him- or herself, the client, and the created image. Leclerc describes this openness as based on the therapist's temporary loss of ego boundaries and sense of self through counter-transference that involves projective identification (p. 132). In a move away from the pathology-orientation, Leclerc suggests that the projective identification involves normal "primitive, non-verbal communication" (Bion, 1962, as cited in Leclerc, 2006, p. 132), an example of which is the aesthetic experience of the created image.

The postmodern view of holding, as described by Kapitan and Newhouse (2000), reflects the function of the relationship between the client and the therapist, with the therapist as the organizing centre, whose openness allows for communication to proceed in its "own" direction, who, at the same time, "seeks connection in diverse places, creating multiple centres of connection... to hold it" (Robbins, 1998, as cited in Kapitan & Newhouse, 2000, p. 116). Holding, like meaning, is not fixed, not a "solid structure," not conceived in a particular way within a singular theoretical framework, and not solution-oriented, but rather, a paradoxical state, an open yet focused "process structure," "fluid," and "adaptable" to the flow of communication (Kapitan & Newhouse, 2000, p. 16). The paradoxical stance of the therapist, which the organizing ability requires, refers to simultaneous and emphatic connectedness and separateness between the therapist and the client. The therapist needs to provide the client with a frame characterized by "clear boundaries of the therapeutic container which attempts to take in toxicity and mirror back acceptance and understanding" (p. 116).

Finley (1988, as cited in Byrne, 1995) observes that the idea of therapeutic change as occurring mainly through a therapist and client's collaborative meaning-making – as

opposed to reflection and interpretation – can be found in Winnicott’s psychoanalytic theory. Winnicott developed this idea based on his observations of mother-and-child non-verbal, physical interactions of holding, touching, and looking, which he viewed as instances when the infant makes meaning. Byrne (1995) argues that an art therapist can re-enact with a client the early non-verbal collaborative meaning-making with a client through Winnicott’s “squiggle game,” play-based interactions with children, and the notion of “transitional space.” Byrne maintains that the experience of a transitional space can minimize the power differential in the therapist-client relationship: by enabling the therapist and the client to experience a blurring of boundaries between reality and fantasy, and between self and other, transitional space can allow for “the paradox of who is whom in such an exchange... to remain” (p. 238).

Social and Communal Aspects of Art Therapy

The postmodern view of reality as highly relative, multicontextual, and fluid, depends on and reflects pluralistic and fragmented contemporary culture (Alter-Muri, 2007; Byrne, 1995). The postmodern attention to “outside” realities and the insistence that all meaning is shaped by context validates the inclusion of socio-cultural, socio-economic, gender, and race issues in therapy (Riley, 1997, as cited in Kapitan & Newhouse, 2000; see also Alter-Muri, 1998). Adopting the postmodern view can therefore increase art therapists’ ability to understand and to provide a more effective intervention for clients living with the challenges of postmodern culture (Byrne, 1995).

Alter-Muri (2007) maintains that the recognition of meaning as constituted within relationships has the effect of blurring the boundaries between the artist and the viewer,

between individual and group creation, between artist's personal concerns and those of the public. According to Alter-Muri, an example where personal and collective meanings and interests can be seen as overlapping is community-based art therapy, which further extends the artist's socio-cultural setting. The example illustrates how strengthening of communities can support a therapeutic change in individual community members (p. 85), empowering both individual and society (Alter-Muri, 2007; see also Alter-Muri, 1998). By inviting visual and verbal responses from other community members, shared community concerns are voiced and a relationship between artists, their art, and community is re-established. Alter-Muri (1998) maintains that the inclusion of visual responses from individual community members provides evidence of multiple ways of viewing and responding to an artwork, validating a multifaceted approach to image-making; no particular technique, medium, or style is more valid than others. The multifaceted approach can reassure and encourage clients who might otherwise reject their unique artistic style based on their assumptions of what constitutes "good" art (Alter-Muri, 1998). The use of "diverse media can cause multiple references to historical, personal, social, and political events" (Alter-Muri, 2007, p. 83). When found discarded objects are viewed as valuable and used in art-making, the art therapist's attention is turned to "culture's necessary psychological tasks.... to what has been discarded and declared useless" (Kapitan & Newhouse, 2000, p. 113), what the world of art and culture at large has silenced, marginalized, and devalued. In the process, oppressed groups of people and silenced aspects of the self can be demarginalized (Alter-Muri, 1998).

Chapter 5: Art Therapy and Eating Disorders

Overview

This chapter presents a review of literature on art therapy with female clients who are diagnosed with eating disorders. The review includes art therapists' theoretical perspectives, therapeutic goals for clients, views about group therapy and community involvement, and art therapy in relation to verbal modalities. The role of the art therapist is considered, followed by a review of the various therapeutic functions of art.

Theoretical Perspectives

The majority of art therapists who describe their work with clients suffering from eating disorders use psychodynamic or psychoanalytic frameworks, particularly object-relations theory (e.g., Acharya, Wood, & Robertson, 1995; Crowl, 1980; Fleming, 1989; Gillespie, 1996; Levens, 1987, 1994abc; Lubbers, 1991; Luzzatto, 1994ab; Macks, 1990; Morenoff & Sobol, 1989; Rehavia-Hanauer, 2003; Rust, 1992, 1994; Schaverien, 1994; Wolf, Willmuth, Gazda, & Watkins, 1985; Wolf, Willmuth, & Watkins, 1986; Wood, 2000). These writers share the view that eating disorders are rooted in a disturbed separation-individuation stage of development, emphasizing the negative influence of the family, especially of the mother. Fleming (1989) combines object-relations theory with self-psychology theory, focusing on a disturbed sense of self. Rehavia-Hanauer (2003) aims for a more complex view using a crossover of theories, yet she stays within traditional psycho-analytic or psycho-dynamic explanations. Mitchell (1980) also remains within traditional psychodynamic perspectives, despite her observations that

“those with anorexia nervosa represent a pathetic illustration of the confused attitudes by society idolizing certain body images” (p. 57) and that “defining” such a complex disorder using a single “psychodynamic formulation has resulted in imposing stereotyped explanations” (p. 54). Hinz (2006) combines a psychodynamic perspective with spiritualism. Matto (1997) takes a unique approach to art therapy, employing it as an adjunct to cognitive behavioural therapy, in combination with community involvement.

Some art therapists challenge the *DSM-IV* categorization of eating disorders into distinct types. Gillespie (1996) and Lubbers (1991) describe obesity, bulimia, and anorexia as “spectrum illnesses” that include an inability to perceive bodily needs and a distorted body-image. Lubbers (see also Rust, 1994) argues for a continuity theory of anorexia and bulimia based on clients’ similar psychological “concerns and behaviours regarding their intense fear of fat” (p. 50). Levens (1994c) addresses diversity within eating disorders, describing women with bulimia and anorexia who are survivors of sexual abuse as suffering from greater impulsivity.

Several art therapists who employ the psychoanalytic or object-relations perspectives acknowledge not only familial but also socio-cultural factors in the development of eating disorders (e.g., Levens, 1994b; Matto, 1997; Rust, 1992, 1994; Wood, 2000). Lubbers (1991) refers to eating disorders as “complex, multifaceted, and multidetermined” (p. 49). Several authors (e.g., Levens, 1994b; Rust, 1992; Waller, 1994; Wood, 2000) explore how women are raised and socialized to attend to the needs of others rather than to their own. Wood (2000) addresses normative notions about body size as well as gender roles. Along with Rust (1992, 1994) and Waller (1994), Wood discusses how patriarchal messages are handed over from mother to daughter. Waller

draws on Orbach's work discussing the role of women's social position and how a daughter's identity is construed through her identification with the mother. Rust (1992, 1994) addresses the patriarchal influence on women's identities, as expressed in the unequal power differential in the social positions between men and women and the underlying dichotomous images of women portrayed as either a whore or a Madonna. She argues that the patriarchal influence leads women to experience the "power of a mature woman... as very threatening" (Rust, 1992, p. 155). Levens (1994b) employs art therapy as well as psychodrama to assist women with eating disorders in exploring their feelings of guilt, confusion, anger, and self-destruction, in relation to the gendered socio-cultural context. She argues that the suppression and distortion of women's anger decreases their power and vitality. Waller (1994) relates the frequency of eating disorders among women to "the symbolic power of food and women's close relationship with it" (p. 79).

Resistance is a well-known aspect of eating disorders, especially of anorexia, but it remains largely unexplored by art therapists. Levens (1994a) views resistance as a consequence of concrete and symbolic thought: "For the patient who cannot readily differentiate between thought and action, certain thoughts must not be had" (p. 172). Drawing on psychoanalytic theories, Rehavia-Hanauer (2003) understands resistance as a basic defence mechanism against internal drives and desires. Mitchell (1980) regards resistance in clients with anorexia as a form of "denial."

Goals of Art Therapy

Art therapists who employ object-relations perspectives define the therapeutic goals for women with eating disorders in terms of maturational tasks related to their disturbed separation-individuation stage of development (e.g., Crowl, 1980; Fleming, 1989; Lubbers, 1991; Luzzatto, 1994ab; Mitchell, 1980; Morenoff & Sobol, 1989; Rust, 1992, 1994; Schaverien, 1994). According to Fleming (1989) increased trust and physical and nutritional needs must be met before work can begin on psychodynamic issues. Morenoff and Sobol (1989) recommend working with pathology rather than focusing on symptom elimination. This involves making changes in the structure of the self by supporting and assisting clients' developmental needs and functioning (see also Crowl, 1980; Fleming, 1989; Luzzatto, 1994ab; Rust, 1992). However, they advise leaving unchanged the defensive structures of individuals who are very fragile, with suspected thought disorder or with suicidal ideation, recommending instead a less intensive cognitive-behavioural therapy.

Group Art Therapy

Compared to individual art therapy, a group setting allows for more "shared personal work" (Morenoff & Sobol, 1989, p. 147) – for sharing oneself with others and including one another in the creative process. Wood (2000) notes that art provides a medium through which the client can relate first to herself and then to other people: first exploring art materials, then visually expressing conflicts in the presence of a therapist, and then in a group painting. Lubbers (1991; see also Hinz, 2006) notes the following benefits of a group setting: increased commitment to therapy through alliances and

witnessing others' progress; increased interpersonal skills and self-esteem among more experienced clients who serve as models to newer clients; reduced isolation and increased mutual support and sense of belonging, enabling learning from one another at different stages of recovery and vicariously. Matto (1997; see also Hinz, 2006) notes also normalization and validation of individual experience. She describes group murals as visual storytelling that can bring a client's attention to how her own story interacts, changes, or stays the same in relation to others' stories, and to the responses these events evoke in her. Yet, as Rust (1994) observes, it is important to balance the group to prevent splitting and scapegoating; and Wood (2000) reflects on how a single male group member in an otherwise female group resulted in a taboo on the discussion of sexuality and gender.

Morenoff and Sobol (1989) remark that it is important to choose art tasks to regulate the extent of sharing, to prevent a sense of intrusion into private unconscious space. Similarly, Fleming (1989) addresses the need to adapt art activities accordingly: clients with anorexia have a greater fear of intrusion; clients with bulimia are eager to "take in." Schaverien (1994) altogether opposes the idea of group therapy for clients with anorexia based on their need for privacy and control. Most writers view group therapy as beneficial for clients with bulimia (e.g., Levens, 1987; Lubbers, 1991; Schaverien, 1994), particularly in cases involving borderline characteristics such as in chronic bulimia (Morenoff & Sobol, 1989). Matto (1997) and Wood (2000) consider the suitability of group therapy based on individual needs.

Art Therapy Compared to Verbal Treatment Modalities

Art therapy is increasingly employed in multidisciplinary treatment settings for eating disorders (e.g., Fleming, 1989; Frisch, Franko, & Herzog, 2006; Levens, 1987, 1994ac; Lubbers, 1991; Matto, 1997; Wolf et al., 1985, 1986; Wood, 2000). Lubbers (1991) argues that integrating art therapy within a multidisciplinary setting diminishes “splitting” in patients, enabling consistency in treatment. Wolf et al. (1985, 1986) argue that art therapy can support and provide a bridge to verbal treatment modalities by enabling clients to symbolize. Mitchell (1980) postulates that art facilitates expression of emotions because, unlike words, it provides a sense of control and thus represents a less threatening form of expression, especially for clients with anorexia. Unlike verbal expression, visual expression can bypass defensive censorship (Fleming, 1989; Hinz, 2006; Rehaviah-Hanauer, 2003) and manipulation (Levens, 1987). Visually expressed ambivalence about recovery can be confronted and overcome, increasing one’s commitment to therapy (Hinz, 2006). Whereas in verbal therapies the emphasis is often on reflecting over past actions and events, art-making brings a focus to present actions (Luzzatto, 1994b). Art is concrete, kinaesthetic, and tangible, providing a greater expressive range than words might provide (Hinz, 2006; Levens, 1987; Luzzatto, 1994ab; Wolf et al., 1985, 1986). Compared to verbal therapies, art therapy techniques can be used to deal more concretely and directly with distorted perceptions of the body (Gillespie, 1996; Rabin, 2003). Matto (1997) describes an integrative approach to treatment where art therapy is used as an adjunct to the cognitive-behavioural modality, complementing it by amplifying the opportunity for an awareness of emotionally-laden problems, enabling women with anorexia to overcome their intellectualization.

Art Therapy and Community Involvement

Matto (1997) argues that both community work and art therapy can enable a more detached relationship to one's eating disorder, allowing one to examine and change factors that have contributed to the development and maintenance of the disorder. Community work can complement the more introspective aspects of art therapy by increasing one's sense of connection to others and community, where women "can begin to find a stronger collective voice" (p. 352). A more productive role in the community can empower, enhance self-esteem, and increase self-agency and assertiveness.

Examples of community activities described by Matto (1997) include the work of the *Media Watch Committee*, which publicizes against body-guilt inducing advertising (Madigan, 1994, as cited in Matto, 1997), and the work of the *Vancouver Anti-Anorexia/Anti-Bulimia League*, where former clients serve as role models for current clients, teaching and providing preventative education based on their expertise regarding their own struggles with eating disorders and overcoming them. Matto suggests also: inviting former clients to mentor those currently in treatment; using art galleries for clients to publicly share and celebrate their work, visually convey stories, and experience validation from the community; and, inviting clients to advocate for implementation of relevant social resources.

Role of the Art Therapist

Several art therapists emphasize their role as a witness (Fleming, 1989; Luzzatto, 1994ab; Schaverien, 1994). Schaverien (1994) stresses art therapists' role in helping clients to engage and find refuge in their creative process. For Fleming (1989), providing

clients with soothing, empathy, and tension modulation enables the development of clients' own self-regulation; the therapist mirrors the client not only through verbal reflection but also through art materials and themes that match the client's developmental and treatment stage. The art therapist ensures safety, models, acts as an auxiliary ego, and provides structure relative to the client's needs for independence (see also Levens, 1987, 1994a; Rust, 1992, 1994; Wood, 2000). The degree of structure or art directives varies among art therapists (e.g., Levens, 1994a; Lubbers, 1991; Mitchell, 1980; Morenoff & Sobol, 1989; Rust, 1992; Wolf et al., 1985, 1986).

Levens (1994b) remarks about the need for a psycho-dynamically oriented art therapist to be aware of the socio-cultural context – that their interactions with clients are embedded in cultural histories. Many art therapists emphasize taking great care when making interpretations (e.g., Fleming, 1989; Matto, 1997; Mitchell, 1980; Morenoff & Sobol, 1989; Rust, 1992). Even curiosity can be experienced as too invasive (Schaverien, 1994) and may reaffirm the client's sense of being controlled (Morenoff & Sobol, 1989). According to Mitchell (1980), interpretations can interfere with individuation. Therapists should be non-judgmental, describing only the explicit graphic content (Mitchell, 1980; see also Morenoff & Sobol, 1989). An artwork does not need to be talked about; sometimes, art process “may be a complete expression in its own right” (Rust, 1992, pp. 160-161; see also Schaverien, 1994). Conversely, Luzzatto (1994b) emphasizes “the separation of the patient from the image through words” (p. 66).

Therapeutic Functions of Art

Art as a mediator in the client-therapist relationship.

Art therapists (e.g., Matto, 1997; Schaverien, 1994; Wood, 2000; see also Lubbers, 1991; Luzzatto, 1994ab; Rehaviah-Hanauer, 2003; Rust, 1992, 1994) describe art therapy as a triangular system where the artwork mediates and acts as a distance regulator between the therapist and the client. Relating to another person through an art object, rather than directly through words, facilitates a non-intrusive relationship that respects the need for privacy that is so important especially to a client with anorexia (Schaverien 1994; see also Rust, 1992). Rust (1994) writes that image-making allows the client to have a private dialogue with herself that, unlike an internal or a verbal dialogue, is seen. Rehaviah-Hanauer (2003) contends that a creative process that honours the client's autonomy and privacy enhances the therapeutic relationship. Similarly, Wood (2000) refers to the importance of client's active involvement and initiative.

Art therapy is effective because of "double transference" (Luzzatto, 1994ab; see also Rust, 1994; Schaverien, 1994; Wood, 2000). The client's more dysfunctional psychological aspects are projected onto the image and her more functional aspects are projected onto the therapist (Luzzatto, 1994ab). Levens (1987), who describes different ways of working with clients diagnosed with anorexia or bulimia, suggests that the client's transference can be explored solely through images. Clients with anorexia or bulimia often experience art materials as symbolizing food. Consequently, instead of projecting their feelings solely onto the therapist, clients tend to project their conflicts and split off aspects of themselves into their art, "which then allows for a visual feedback

to reflect, or mirror back, certain projected, or disowned qualities” (pp. 5-6). Art as a receptacle of transference material can be used to explore clients’ feelings toward the therapist, through “the patient and therapist painting together, or by looking at the art in relation to the developing transference relationship” (p. 5). Schaverien (1994) describes the function of artwork as a substitute for food; as a transactional object through which negotiations take place between therapist and client yet without direct references to food, an artwork minimizes the client’s resistance. A more enjoyable experience for the client, which in turn enhances the therapeutic alliance, is made possible because instead of verbally “attacking” the therapist, a client can express angry transference feelings to the therapist visually (Rust, 1992) and the pressure to have to talk during art-making is eliminated (Lubbers, 1991; Mitchell, 1980).

Art as an indicator of conflicts and defences.

Art therapists view art as a graphic indicator of clients’ core conflicts and defences (e.g., Acharya et al. 1995; Crowl, 1980; Hinz, 2006; Levens, 1987, 1994abc; Lubbers, 1991; Mitchell, 1980; Morenoff & Sobol, 1989; Rehaviah-Hanauer, 2003; Rust, 1994; Wolf et al., 1985, 1986; Wood, 2000). A client’s artwork and style of engagement with art materials parallels her way of relating to food, body, and self, corresponding to her type of eating disorder (e.g., Acharya et al., 1995; Gillespie, 1996; Levens, 1987; Lubbers, 1991; Matto, 1997; Rust 1994; Schaverien, 1994; Wood, 2000). Levens (1987) regards this as a result of the power of art materials to evoke the experience of bodily sensations. Images by obese clients appear vague and sketchy, with poorly outlined body contours, corresponding to deficient self-definition (Gillespie, 1996). Hyper-realistic and

idealized depictions of female bodies by clients with bulimia match their externally defined identities (Gillespie, 1996); their chaotic and messy way of working with art materials is analogous to their binge-purge cycle and acting-out behaviours (Lubbers, 1991). Images produced by clients with anorexia have firm outlines and tend to depict cartoonish, ridiculed, and fat bodies (Gillespie, 1996); their controlled and restrained engagement with materials parallels their controlled starvation of the body and restrained affect (Lubbers, 1991). Luzzatto (1994ab) describes a recurring image called a “double trap” among clients with anorexia that refers to their resistant and conflictual communication: “I need you – but you must not help me.”

Art as an assessment tool.

Therapists use art to identify and work with clients’ developmental issues (Gillespie, 1996; Lubbers, 1991; Morenoff & Sobol, 1989; Wolf et al., 1985, 1986) including defects in the structure of the self (Morenoff & Sobol, 1989). Clients’ art is also used as an index of their therapeutic progress (Crowl, 1980; Gillespie, 1996; Morenoff & Sobol, 1989) and their level of involvement in therapy (Wolf et al., 1985, 1986). Lubbers (1991) describes the use of art therapy assessments such as *House-Tree-Person* (Buck, 1974, as cited in Lubbers, 1991) and *Family* (Burns & Kaufman, 1972, as cited in Lubbers, 1991) throughout the duration of treatment. Kessler (1994), who examined the *Diagnostic Drawing Series* assessment tool, found that images created by individuals with eating disorders differ from those created by a control group in regards to the incidence of falling-apart trees and ground line characteristics.

Self-integrative and ego-strengthening functions of art.

Art therapists who adopt the object-relations framework explain the role of art in terms of repairing psychological deficits related to the separation-individuation stage of development which enables emotional or psychological maturation (e.g., Acharya et al., 1995; Fleming, 1989; Levens, 1987; Lubbers, 1991; Macks, 1990; Wood, 2000). The creative process of art-making strengthens ego and supports self-esteem by facilitating self-expression, imagination, and autonomy (Acharya et al., 1995; Wood, 2000; see also Matto, 1997). Transforming chaotic emotions and impulses into images develops clients' sense of mastery and control (Fleming, 1989; Lubbers, 1991; Macks, 1990; see also Hinz, 2006; Matto, 1997). Creative accomplishments promote a sense of pride (Hinz, 2006; Matto, 1997). Images that are of one's own making and involve active engagement, self-directedness, and self-expression, promote a less passive and more empowered identity (Levens, 1987; Matto, 1997; see also Hinz, 2006; Rust, 1992). An artwork serves as a "functionally or a symbolically meaningful self representation" (Macks, 1990, p. 24), an experience of new meaning toward self-growth (Fleming, 1989) and toward seeing beyond symptoms (Hinz, 2006). Artworks that are kept after the end of therapy can remind clients of their strengths, accomplishments, and the relationships they formed during therapy, serving to motivate and to boost self-esteem (Fleming, 1989; Lubbers, 1991). Clients can continue to make art toward personal growth (Hinz, 2006).

Art-making can increase self-awareness: it can enable expression of unconscious material, creating an opportunity to confront, acknowledge, examine, and accept emotions, thoughts, and early memories (Acharya et al., 1995; Fleming, 1989; Hinz, 2006; Lubbers, 1991; Macks, 1990; Matto, 1997; Mitchell, 1980; Rust, 1992). Hall

(1987, as cited in Matto, 1997) views art-making as a process of integrating cognitive understanding with affective experience. Expressing and experiencing raw emotion can bring one into the present (Rust, 1994) and create an opportunity for catharsis, for playing out one's issues such as loss of and need for control (Lubbers, 1991). Clients experience the paradoxical nature of feelings – not only their destructive but also their empowering and creative force (Rust, 1994). Clients learn to tolerate their feelings and anxieties by expressing them in the safety of a supportive therapeutic environment (Fleming, 1989). The concrete presence of images can serve to access and initiate a dialogue with various aspects of one's eating disorder (Morenoff & Sobol, 1989; see also Acharya et al., 1995; Levens, 1994a; Luzzatto, 1994ab; Matto, 1997; Rehaviah-Hanauer, 2003), increasing clients' sense of responsibility for their emotions (Mitchell, 1980). Previously split off conflicts, which can be viewed as unconscious aspects of the self, can be integrated (Fleming, 1989; Hinz, 2006; Lubbers, 1991; Mitchell, 1980; see also Matto, 1997), facilitating a restructuring of the self, and a more stable, less conflicted and more coherent identity (Levens, 1994a; Morenoff & Sobol, 1989; see also Schaverien, 1994). Clients who are suffering from eating disorders can use artwork to figuratively experiment with various versions of themselves, such as different body sizes, with which they associate both positive and negative feelings, and come to realize that these different images are different aspects of themselves and that they can identify with all of them as opposed to only one (Rust, 1992).

Art as a means to reconnect with one's body.

When addressing the mind-body split in women with eating disorders, many art therapists value the physicality of art materials and the embodied process of image-making (Acharya et al.1995; Crowl, 1980; Gillespie, 1996; Levens, 1994a; Lubbers, 1991; Macks, 1990; Wood, 2000). Levens (1994a) emphasizes the close link between clients' relationships to their own bodies and their sense of ownership over their thoughts and emotions: "Many memories are stored in the body and re-called at a pre-verbal level, which can then be made conscious. By... paying attention to their body signals... their body consciousness is also increased" (p. 165). Likewise, Rust (1992) refers to an artwork as an "intermediary preconscious messenger" (p. 162). Just as clients project their relationship to food and body onto the artwork, so also they project their inner sense of self onto painting or clay sculptures, which Gillespie (1996) calls "body images" (p. 161). Macks (1990) explores how the physicality of clay and its way of "asking" to be shaped into a container can parallel the body, historically symbolized by a vessel. Clients can also use clay to represent their genital space, beginning to explore and connect with their bodies and their gender identifications. Many art therapists (e.g., Crowl, 1980; Matto, 1997; Rabin, 2003; Wood, 2000; see also Levens, 1987, 1994a) describe directive art therapy techniques such as body tracing as tools for clients to explore their bodies and their objectification, and to bridge the discrepancy between actual body size and a distorted image of it, creating the opportunity for a more realistic self-image to develop.

Art as a means to develop the ability to symbolize.

Art therapists who use object-relations perspectives in their work with eating disorders relate their clients' concrete expression of distress to difficulties with metaphorical thinking or symbolizing; they argue that art can serve to develop their clients' metaphorical or symbolic way of perceiving (Levens, 1994ac; Lubbers, 1991; Rust, 1992, 1994; Schaverien, 1994). The concrete, kinetic, and tangible quality of art materials and of the final artwork engages the body and evokes bodily sensations, matching the clients' need for concreteness, to "act out" their unconscious conflicts and distress using food and body (Rust, 1992). By dealing more directly with their concrete experiences, women can develop an ability to symbolize or more consciously "enact" their bodily experiences (Levens, 1987, 1994ac; Rust, 1994; Schaverien, 1994; see Wolf et al., 1985, 1986; Wood, 2000). By enacting inner states through pictures, which Wood, using Schaverien's term, calls "embodied images" (Schaverien, 1999, as cited in Wood, 2000), clients can become more conscious of their feelings. Schaverien (1994), for example, discusses how an art product can, through transference, become a symbolic substitute for food, embodying the associated conflicts and emotions; clients use the art product, as they do food, to negotiate control with others, and these negotiations may lead to a more conscious enactment. Wood (1996) observes that Schaverien's (1994) emphasis on art-as-product is not shared by other therapists, who describe recovery as a more complex process: "Substituting art for food does not necessarily transform the eating disordered behaviour into something creative and integrative, but can reinforce it by extending the client's repertoire of acting out behaviours" (Wood, 1996, p. 16), as in the case of "vomit pictures," which refer to clients' use of art materials to act out their

emotions without reflecting (Levens, 1987). Art therapists emphasize that it is crucial for therapists to be aware of the distinction between enacting and acting (Dokter, 1994; Levens, 1987, 1994ac; Rust 1992; Wood, 1996; see also Acharya et al., 1995), otherwise art-making can exacerbate clients' defensive acting-out behaviours.

Art as a metaphor for psychological space and boundaries.

Concrete space provides a range of movement and privacy in the therapist's presence, increasing the client's sense of autonomy toward maturation, separation and individuation (Luzzatto, 1994ab; see also Levens, 1994a; Schaverien, 1994; Wood, 2000). The tangible and concrete frames, boundaries, and outlines of artworks "may be particularly valuable to the anorexic patient who often has difficulties in recognizing her own boundaries, both physical and psychological" (Lunn, 1990, as cited in Acharya et al., 1995, p. 242). The frames can help clients to overcome their fears of becoming overwhelmed, fulfilling their need for control, providing them with a means to express and contain unconscious conflicts, and painful or chaotic emotions (Acharya et al., 1995; Lubbers, 1991; Macks, 1990; Rust, 1992; Schaverien, 1994; Wolf et al., 1985, 1986; Wood, 2000). As a solution to the paradoxical anorexic situation portrayed in "double trap" images, Luzzatto (1994ab) invites clients to imagine stepping outside the trap and meta-communicating about it. She describes the movement from being fused with the image during the creative process to looking at the image from a distance, discussing and exploring spatial relationships, as a parallel to separation from the mother. Similarly, the picture frame separates and distances clients from their images, distancing them from their fears; at the same time, it opens a space to look at these images and to bring them

nearer to consciousness (Schaverien, 1994; see also Luzzatto, 1994ab). Creating and working with concrete space enables clients to develop mental “space” within which to symbolize their conflicts and to recognize their needs (Levens, 1994a).

Art as a transitional object.

From a psychodynamic perspective, women with eating disorders cannot separate cognitively and psychically from their mothers (Fleming, 1989). As they did not receive enough holding, mirroring, and soothing, they cannot transfer these needs to a transitional object and internalize them as aspects of themselves (e.g., Fleming, 1989; Macks, 1990; Rust, 1992; Schaverien, 1994; Wolf et al., 1985, 1986; Wood, 2000). Instead, they continue to unconsciously act out through their bodies (Levens, 1994a). By virtue of being external to the body and providing another means to express distress, the artwork may become a transitional object. Through a direct engagement of one’s body during art-making, the client has an opportunity to test feelings by metaphorically “binging” or “vomiting” rather than acting out using food (Rust, 1992).

According to Winnicott, an artwork mediates between the client and the therapist in the transitional space, where the therapist is experienced as the parent, typically the mother (Schaverien, 1994). The experience of being held by the therapist creates an opportunity for the client to metaphorically undergo a repair of the early relationship with her mother (Macks, 1990). Visually expressed material can be witnessed, held, and survived by the therapist; and, due to its concreteness, art can survive also in the therapist’s absence, outside sessions and after the termination of therapy (Rust, 1992), enabling a movement toward separation-individuation, effectively developing the

abilities to symbolize and to relate to others as a separate individual (Schaverien, 1994).

Art as a means to exploring socio-cultural context.

Matto (1997; see also Hinz, 2006) describes how working with magazines or multi-media collages can prompt a discussion about internalized messages from popular culture and their role in the development and maintenance of one's eating disorder, facilitating an exploration of broader socio-cultural influences and decreasing self-blame. Matto describes also how mask-making can serve as a metaphor that enables a confrontation of feelings associated with restrictive social pressures – symbolized by the increasing tightness of plaster as it hardens – that contribute to one's identification with the “false” self – symbolized by the mask – and dissociation from one's “true” self – symbolized by what is hidden under the mask. Hinz (2006) claims that art-making enables exploration of both personal as well as collective symbols and healing themes.

Art serves many therapeutic functions, as described by art therapists who primarily use object-relations theory in their work with individuals with eating disorders. Many of these functions relate to the concrete and embodied aspects of art, which the therapists deem as valuable when working with clients who experience body-image issues, express themselves concretely, and need to develop their ability to symbolize, toward separation-individuation, self-integration, and ego-strengthening.

Chapter 6: Summary and Discussion

A therapist's theoretical perspective influences his or her practice. The purpose of this paper is to provide an answer to the following question: how might feminist post-structuralist theories inform art therapy with women diagnosed with eating disorders? Feminist post-structuralists share a view that an eating disorder represents a woman's attempt to resolve contradictory femininity – an identity that is construed negatively as the other of the masculine self. This discourse of femininity is embedded in the mind-body duality within which the body is associated with the feminine attributes of emotionality, passivity, and construed as a threat to the mind; the mind is associated with the masculine attributes of rationality, autonomy, control, and is idealized and equated with the self. Feminist post-structuralists theorize that an eating disorder is not a personal pathology but is embedded in the disordered self-other relationship (Hoskins, 2002). Highlighting the self-other relationship draws attention to the wider socio-cultural issues of gender and gendered power relationships. The post-structuralist view of gendered subjectivity as constituted within linguistic and material discourses, multiple and shifting, has allowed for a deconstruction of contradictory discourses of femininity (e.g., Hoskins, 2002; Lester, 1997; MacSween, 1993; Malson, 1997, 1998, 1999; Malson & Ussher, 1996a, 1997; Moulding, 2007) and for a problematization of psycho-medical discourses (e.g., Burns, 2004; Eivors et al., 2003; Guilfoyle, 2001; Hepworth, 1999; Malson, 1997, 1998; Malson et al., 2004; McVittie et al., 2005; Moulding, 2003; Moulding & Hepworth, 2001).

The review of literature on art therapy with eating disorders (see Chapter 5)

shows relatively little attention paid to feminist post-structuralist concerns, such as the socio-political context, the power-differential in the therapist-client relationship, and patriarchal assumptions underlying developmental theories, including notions of health and identity, and constructions of femininity. These particular concerns are addressed in feminist and postmodern art therapy literature, which was reviewed within this research in the hope that it could provide ideas for an approach to art therapy with eating disorders that is congruent with feminist post-structuralist principles.

Feminist post-structuralists argue that subscribing exclusively to a theory, such as the positivist psycho-medical approach, that ignores the socio-cultural context and makes claims to universal and objective truths, reproduces oppressive patriarchal discourses, thus reinforcing eating disorders (e.g., Burns, 2004; Eivors et al., 2003; Gremillion, 2002; Hepworth, 1999; Lester, 1997; Malson, 1997; Moulding, 2003; Moulding & Hepworth, 2001). Most art therapy literature dealing with eating disorders is written from the perspective of object-relations theories, emphasizing the negative influence of the family, especially the role of the mother, in the daughter's development of an eating disorder. The few art therapists who go beyond family and personal dynamics to include socio-cultural and political factors in the development of eating disorders discuss normative notions about the body, the patriarchal influence on women's identities (Rust, 1992, 1994), the power of food and women's close association with it (Waller, 1994), women's subservient role and how patriarchal messages are passed on to the daughter by the mother (Wood, 2000). Feminist post-structuralists maintain that an understanding of socio-cultural factors in the aetiology of eating disorders needs to address the underlying gendered mind-body discourse.

An awareness of the gendered mind-body discourse can enable art therapists to recognize and examine the patriarchal assumptions that are entrenched in psychological theories and that underlie notions of identity, subjectivity, health, illness, and recovery, thereby reducing the possibility of reproducing the oppressive discourse of contradictory femininity. Burt (1997), a feminist art therapist, argues that traditional developmental theories are embedded in the masculine notion of autonomous identity. Burt's arguments can be extended as a challenge to object-relations theories which view development as a movement toward a separate self. By framing therapeutic goals in relation to incomplete separation and individuation, art therapists reproduce the discourse of autonomous identity and reinforce feminine identity construed as negative or lacking. The focus on pathology and incomplete self is inconsistent with feminist post-structuralist theory, which emphasizes wellness, empowerment, and change of identity through the awareness of the role of gendered socio-cultural factors in the development of eating disorders.

Ignoring the fundamental power imbalance between the masculine self and its feminine other has the effect of displacing the gender conflict by locating it within individual girls and women who are diagnosed with eating disorders (Hoskins, 2002). Women's resistance is dismissed as a pathological symptom or a self-defence mechanism (e.g., Levens, 1994a; Mitchell, 1980; Rehavia-Hanauer, 2003), thereby reproducing the discourse of femininity within which women are construed as passive and prone to mental illness. The feminist post-structuralist view of multiple and socio-culturally constructed meaning could inform art therapist's view of resistance to include its more positive meaning: resistance as an expression of power, as an active stance against being defined externally (see Guilfoyle, 2001; Malson et al., 2004). Art therapists describe

image-making as having the effect of bypassing clients' resistance; however, a more positive view of resistance could enable a more direct way of dealing with it.

Recognizing that clients are empowered through their resistance shifts the emphasis away from pathology.

Adopting the feminist post-structuralist view of identity and meaning as multiple, shifting, contradictory, and construed discursively in relationships enables clients to: learn to tolerate ambiguity, paradox, and complexity; become aware of the multiple ways in which culture and society contribute to their distress; rid themselves of the immobilizing effects of self-blame; and better deal with the ongoing challenges of postmodern life. Viewing femininity as socially constructed and contradictory sensitizes art therapists to their clients' verbal and visual gender references, and to regard their depictions of female figures in relation to other cultural representations of women (e.g., Hogan, 1997b). Viewing images as both personal and social facilitates one's understanding of personal conflicts within the context of wider socio-political conflicts. Davis Halifax (2003), who employs a postmodern framework in art therapy, challenges modern art's patriarchal notion of representation: by deemphasizing universality and the timelessness of artwork, and by not idealizing the artist's originality (Gablik, 1993, 1995, as cited in Davis Halifax, 2003), one can attend to the gendered socio-cultural dimension of art.

Feminist post-structuralist perspectives draw art therapists' attention to issues of gender and power within the treatment context. Although art therapy with clients diagnosed with bulimia, and especially with anorexia, is often conducted within a hospital treatment setting, the patriarchal influence of the psycho-medical environment

remains generally unaddressed. With the exception of Wood (2000), the literature on art therapy with eating disorders ignores treatment issues related to power and gender, such as the role of the art therapist's gender, his or her body, and the power differential within the client-therapist relationship. Wood makes interesting observations, for example: issues related to gender and sexuality were not raised when a single male was present in an otherwise female group, thus preventing women from exploring how their eating disorders are related to discourses of femininity. The literature on art therapy with eating disorders is unclear as to whether the treatment goals take into account clients' own wishes, and whether the interpretations of images that are being described are made by therapists or made by clients.

To increase the extent of clients' active participation in therapy, to empower them, it is important to consider their unique perspectives and desires. Feminist post-structuralists view clients' resistance in traditional verbal therapies as a protest against being defined in psychological terms (e.g., Guilfoyle, 2001; Malson et al., 2004). In comparison to traditional verbal therapies, using image-making and visual metaphors can empower clients by giving them a greater freedom to express themselves. As described by Alter-Muri (2007), for an art therapist who employs a postmodern perspective, metaphors carry multiple entry points into a client's subjective experience. The therapist's act of witnessing a visual image validates the client's perspective, and this type of communication minimizes the power differential between the client and the therapist.

Feminist post-structuralists favour multi-disciplinary approaches to the treatment of eating disorders where social, psychological, and physical dimensions are integrated.

Wolf and colleagues (1985, 1986), who work with women diagnosed with eating disorders, describe art therapy as providing an alternative, visual mode of expression and communication, which functions as a support and a bridge to verbal treatment modalities. A community-based approach to art therapy has been described by Matto (1997), who also works with clients diagnosed with eating disorders, and by Alter-Muri (1998, 2007). Community-based art therapy exemplifies feminist post-structuralist principles: extending the meaning of artworks to their socio-cultural setting, empowering both communities and individual participants by facilitating their active involvement, opening lines of communication, and introducing a multifaceted approach to art-making and multiple ways of responding to art. Multiple perspectives can diffuse the power imbalance between the client and the therapist.

A number of art therapists, while not practicing community-based art therapy, discuss group art therapy as especially suitable for clients diagnosed with bulimia, some extending it to those diagnosed with anorexia. Depending on a particular client's wishes, a group therapy setting can be viewed as congruent with feminist post-structuralist perspectives. As a collective microcosm, a group setting shifts the focus in art therapy away from achieving a separate identity and toward engaging with others and enhancing inter-relational skills. By observing how one's own stories and visual images interact with and change in relation to those of other group members, clients can learn how meaning is multi-determined, constructed and reconstructed within relationships. Given the opportunity to witness shared aspects of their experiences, clients can examine their eating disorders within a wider socio-cultural context rather than viewing them as discretely personal problems.

Art therapy originated from psychoanalytic theory, and psychoanalytic theory is compatible with the feminist post-structuralist framework. Feminist post-structuralists have appropriated elements of the theory, particularly its notions of gendered embodied subjectivity, of identity based on an illusory sense of wholeness, and of the patriarchal constitution of feminine identity that is defined negatively through language. Lacan theorized that one's sense of a uniform identity, based on identification with the mirror reflection of one's body, is an illusion. The image is a partial representation of one's body that does not represent all of one's bodily movements, subjective sensations, or the unconscious (Robertson, 1992). Feminist post-structuralists emphasize that meaning and subjectivity are embodied, context-sensitive, multiple, and continually reconstructed.

Applied to art therapy, Lacan's and feminist post-structuralist ideas highlight the importance of attending not just to the abstract symbolic content of the final product but also to the embodied process of image-making. The literature on postmodern art therapy presents an integrated view about art product and process. The literature on art therapy with eating disorders seems to be less consistent; some authors focus on the symbolic content of the final product, while others explore the therapeutic value of the concrete and embodied process of image-making, especially in facilitating the development of an ability to symbolize, an ability which most agree is deficient among women diagnosed with eating disorders. Lacan's ideas about the mirror-stage support the notion of symbolization through looking at and discussing images. The idea of the illusory sense of uniform self implies the need to view images as representing various and changing versions of the embodied self in relation to multiple contexts, including the context of art therapy, the client-therapist relationship, client's previous experiences, and their wider

socio-cultural context.

Psychoanalytic theory emphasizes the role of visual experience in identity formation, and feminist post-structuralists further emphasize the role of visual experience in eating disorders. For example, they analyze the disappearing anorexic body as an expression of absent femininity; they explore the tendencies for self-monitoring and self-surveillance; and, they explore the objectification of the feminine body into body-as-image. In line with feminist post-structuralist theories, feminist art therapists (e.g., Davis Halifax, 2003; Fabre-Lewin, 1997; Ross, 1997; Vellet, 2004) address women's internalization of oppressive discourses found in patriarchal visual images and language. The idea that eating disorders represent the patriarchal oppression of women has been explained through the feminist post-structuralist notion of the economy of visibility, and the related notion of the patriarchal disciplining gaze (e.g., Malson & Ussher, 1997; see Chapter 2, section entitled "Discourses of absent femininity identity"). By emphasizing the visual aspect of experience, art therapy is particularly suitable for women diagnosed with eating disorders. For instance, the tension that a female client feels during image-making can be related to her experience of taking on the traditionally masculine active role when viewing the image, while the viewed image takes on the feminine passive role (Pollock, 1988, as cited in Hogan, 1997b).

Women diagnosed with eating disorders are known for their conflictual relationships with their bodies. Their bodies have become what feminist art therapists (e.g., Fabre-Lewin, 1997; Hogan, 2003b) describe as sites of socio-political oppression and resistance. As sites of expressed unconscious conflicts, images can be read as paralleling the devalued scapegoated feminine body (e.g., Schaverien, 1992, as cited in

Vellet, 2004), objectified and construed into an aestheticized image, as a surface with inscribed patriarchal discourses. Whereas the process of expressing emotions and of becoming aware of unconscious conflicts can undermine the patriarchal notion of bodily emotions construed as threatening the mental self, the active engagement of one's body during art-making (see Schaverien, 1992, as cited in Vellet, 2004) can undermine the passive and devalued construction of the body. Art therapy can thus subvert the gendered mind-body discourse, redefining meanings associated with mind and body, with femininity and masculinity, moving the client closer to psychic reconciliation and experiencing her body as sensate rather than merely objectified.

Approaches to art therapy that are compatible with the feminist post-structuralist framework, although not often written about or published, might already be practiced. As discussed by some feminist art therapists (e.g., Joyce, 1997; Talbott-Green, 1989), literature on these approaches might be prevented by the gendered hierarchy about mental health expertise in research and publishing. An awareness of the unique advantage of art therapy related to the concrete and embodied process of image-making, its capacity to empower clients and to subvert the gendered mind-body discourse, including contradictory femininity, can free art therapists from the pressures of a patriarchal professionalism. Art therapists' increased confidence in their trade can be translated into practice, furthering their ability to empower clients.

This research paper has focused on eating disorders as diagnosed among the Western female population. The study has not addressed eating disorders as diagnosed among the male population, although an increased incidence of eating disorder diagnoses among boys and men has been documented (Braun, Sunday, Huang, & Halmi, 1999;

O'Dea & Yager, 2006). The study focused on Western notions of femininity and masculinity as embedded in a gendered mind-body discourse, ignoring multi-cultural and ethnic issues. Also ignored were age differences. The orientation of this paper is theoretical. The discussion of the implications of feminist post-structuralist theories of eating disorders for the practice of art therapy is preliminary and speculative, based on a literature review, and not based on direct clinical practice. The research assumes that art therapy is generally effective when used with women suffering from eating disorders. Finally, the paper is not concerned with examining the effectiveness of art therapy with this population, which could be accomplished, for example, through long-term follow up studies. Future investigations into the effectiveness of art therapy as informed by feminist post-structuralist perspectives might also be extended to include females who have not received an official diagnosis of anorexia or bulimia, yet who experience distress over body-image, weight, and food, all of which are implicated in the development of eating disorders.

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