

**Anorexia Nervosa in Adolescence:
An Exploration of the Personal Unconscious in Art Therapy**

Véronique Brun

**A Research Paper
in
The Department
of
Creative Arts Therapies**

**Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada**

March 2006

© Véronique Brun, 2006



Library and
Archives Canada

Bibliothèque et
Archives Canada

Published Heritage
Branch

Direction du
Patrimoine de l'édition

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file *Votre référence*
ISBN: 0-494-14356-8
Our file *Notre référence*
ISBN: 0-494-14356-8

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protègent cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.


Canada

Abstract

Anorexia Nervosa in Adolescence: An Exploration of the Personal Unconscious in Art Therapy

Véronique Brun

The proposed research consists of a single descriptive case study, exploring the unconscious aspects of anorexia nervosa in the context of art therapy. The general concepts and theories on anorexia nervosa in adolescence will be explored. The psychoanalytic approach will also be of subject in order to inform the reader on the psychoanalytic concepts utilized for this paper. The participant of the study is a 14-year-old outpatient girl diagnosed and treated for anorexia nervosa. Based on Jungian concepts, interpretation of the case material and artwork will be of main subject in order to help identify manifestations of the personal unconscious. Each phase of the art therapy treatment will be explored, including the alliance, the resistance, the problematic and the termination. This study proposes that the use of art in therapy could lead to a better understanding of anorexia nervosa, assuming that art could be a manifestation of unconscious processes. The results of this case study indicate therapeutic progress. No specific causality could be identified. However, a combination of complex issues related to this patient's life experiences could be the cause of anorectic behaviour. Because this research is a single descriptive case study, the results cannot be generalized.

Acknowledgements

I would like to thank the Concordia Art Therapy Department for your support and guidance. Many thanks to Louise Lacroix, my research advisor, for your revisions and feedback, including the encouragements, patience and positive regard. You have been a good resource whenever I was in need. I am very grateful for all. For my practicum supervisors, thank you for your support and guidance. I would like to give a warm thanks to Sally Cooke for giving me this fulfilling opportunity. Your support, guidance and encouragements are appreciated just as your sense of humour. I would also like to give thanks to the hospital staff, including the physicians, social workers, nurses, dieticians and administrative assistants for your faith in my abilities to be of help to their patients. Your feedback was always appreciated.

Thanks to Jenne Newman and the friendship that I have found in you. You are missed! And the art therapy gang, this experience was not only rich in learning but also in companionship. Special thanks to my patient for your courage to share your story. I hope you know how much you have taught and inspired me to be the art therapist that I aspire to be. To my parents and sisters, thank you for your unconditional love, support and encouragements. To Russel, thank you for your love, patience and understanding. I know this has been a long process for both of us.

I would like to dedicate this paper to my dear sister Chantale. Your endless encouragements, thoughts and feedback made the realisation of this paper possible. Thank you for your sense of humour, your visits and your expertise in research. Our laughs and discoveries are forever cherished. I thank you for being the person you are. My life would not be the same without you!

Table of Contents

List of figures.....	vii
Introduction.....	1
Chapter 1 – Anorexia Nervosa in Adolescence.....	7
1.1. Anorexia Nervosa.....	7
1.1.1. Diagnostic Features.....	7
1.1.2. Analytic Perspective of Diagnostic Features.....	8
1.1.3. Prevalence.....	9
1.1.4. Physiological Consequences.....	10
1.2. Etiology of Anorexia Nervosa.....	11
1.2.1. Existing Theories.....	11
1.2.2. Treatment.....	15
1.3. Summary.....	18
Chapter 2 – Psychoanalytic Approach and Art Therapy.....	19
2.1. General Jungian Concepts.....	19
2.1.1. The personal unconscious.....	20
2.1.2. Archetypes.....	20
2.1.3. The meaning of symbols.....	22
2.2. Jungian Concepts Applied to Art Therapy.....	23
2.3. Fairy Tales used as a Therapeutic Tool.....	25
2.3.1. Archetypes in fairy tales.....	27
2.4. Summary.....	28
Chapter 3 – Anorexia Nervosa in Adolescence: An Exploration of the Personal Unconscious in Art Therapy.....	29
3.1. Single Descriptive Case Study: Art Used as a Method of Expression....	29
3.1.1. Patient Identification.....	29
3.1.2. Agency.....	30
3.1.3. Facilities.....	31
3.1.4. Art Supplies.....	32
3.2. Therapeutic Goals.....	33
3.2.1. The Art Therapy Approach and Techniques Used.....	34

3.3. Description of the Art Therapy Sessions.....	35
3.3.1. Establishing the Therapeutic Alliance.....	35
3.3.2. The Resistance.....	44
3.3.3. Looking Closer at the Problematic.....	48
3.3.4. The Termination.....	54
3.4. Interpretation of Mary’s Favorite Fairy Tale.....	57
3.5. Discussion.....	60
References.....	63
Appendices	
1. Patient Artwork.....	69
2. Consent Information.....	77
3. Consent Form.....	78

List of Figures

Figures	Pages
1. Figure 1: “Relief”	69
2. Figure 2	70
3. Figure 3: “A Happy Family”	71
4. Figure 4	72
5. Figure 5	73
6. Figure 6	74
7. Figure 7	75
8. Figure 8	76

Introduction

“I remember... the children’s cries as they were brutally torn from their mother’s breasts, the mother’s horrified and powerless expressions at the sound of soldiers’ firm footsteps, the comforting voice of a husband’s wishful thinking of their survival, a family’s plead for their right of ownership of their land. I remember these feelings of being lost, frightened and alone. Engrained within, I remember the fright and shame of loosing everything. I remember the trauma. I remember my ancestors’ trauma.”

Véronique Brun, 2005

During a televised documentary on the resiliency of the Acadian People, interesting questions came to my attention that helped initiate this research project.

Zachary Richard, a famous Acadian singer, was interviewing the elderly people from his hometown, la Louisianne. They were telling a tale of a different time, a tale that sounded and felt familiar. Mr. Richard seemed to believe that the Acadian’s strength, courage and resiliency were the primary characteristics that enabled them to survive as a people.

The innocent young child hidden in an elderly grown body was reciting his experiences of growing-up in a world of unfairness. As children, at school they were not aloud to speak in their mother tongue. Not only were they not able to speak French, they were punished for doing so. Their punishment was to write 200 lines “I shall not speak French on school grounds”. Despite this, the children were able to outwit the teachers by using three pencils taped together, which made their punishment less long but not necessarily less painful. This shows a little of their resilient character, which means despite the emotional shock they were experiencing at the time, they had the ability to recover rapidly from it. Another souvenir described by this man was how the French speaking Acadian children used to urinate on themselves at school because they didn’t know how to ask properly in English for permission to go to the washroom. These

children were not only losing their heritage, they were humiliated and disregarded because of it. They grew-up with shame surrounding them for the very thing that made them real. They learned to be ashamed of their identity.

These two experiences shared out of many others unheard, makes me realize how people are resilient, how they are able to bounce back, especially children. But one question still remains, how much impact was left on their behalf? Do events such as these make us stronger as we grow older or do they engrain a lifetime of shame and humility? I keep thinking of how proud I am of my ancestors, for their courage and determination have facilitated continuity and survival. These strong characteristics assured my existence. While watching this documentary I couldn't help my emotional reactions, sensing that this history is part of my being, grounded deep in my gut. Even though I wasn't physically there when it all happened, it almost seems like I can remember how it felt to be there.

I believe that this emotional connection to my ancestors has a lot to do with whom I have become as a learning art therapist and how events in one's life and one's culture can affect who we become as a person. How many children have experienced similar situations throughout history and still do to this day? I strongly believe that the trials and tribulations of a person's past and present need to be validated and not discarded in order to fulfill one's dreams. I also believe that a person's personal and collective traumas can be transformed into something meaningful and positive. Art therapy may be one approach to help facilitate this.

In Jung's (as cited in Feist & Feist, 1998) theory of personality, emphasis is placed on the collective unconscious: "The collective unconscious has roots in the

ancestral past of the entire species... the contents of the collective unconscious do not lie dormant but are active and influence a person's thoughts, emotions and actions." (p. 65).

It seems that my previous reaction to the documentary would support this theory.

Everyone must have similar reactions when it comes to dealing with core issues. Jung also states: "the collective unconscious does not refer to inherited ideas but rather to our innate tendency to react in a particular way whenever our experiences stimulate a biological inherited response" (Jung, as cited in Feist, & Feist, 1998, p.66).

Acknowledgment of this study has made me realize that each client I see in therapy must also have this collective unconscious. Discovering this for myself fostered a curiosity upon my clients' ancestral roots and how this must influence their way of being in the world. This collective unconscious must be somewhat enacted in a person's actual acting-out. It also allowed me to seek for different perspectives on my interventions, and to see how important it is to look at the whole picture in order to see the missing details.

We all have a personal past, including a collective past that both influence our existence. I assume that if the patterns of human interactions keep repeating themselves that this could be evidence of a collective unconscious being transmitted from one generation to another. It seems like the world has not changed much in terms of human relations. Ironically, today's children seem to experience as much trauma as past generations did. Why don't we learn from history? Is it because our collective unconscious is too close for recognition, which could hinder change? To be different in this world usually means to be treated differently. Children usually pay a high price for being different. Then we wonder why these children grow-up with a lack of self-love and act-out in various self-destructive ways. Perhaps the shame and humility of being

different fuels the acting-out. Furthermore, these feelings and emotions may be part of the collective unconscious as well as of the personal unconscious. I am not saying that this shame and humility actually comes from past generations, however they may somewhat be linked. For instance, how parents were brought-up will most likely influence how they bring-up their children. In other words, ways of relating to others are somewhat passed on from one generation to the next.

During my second year practicum, I have worked mostly with young adolescent girls diagnosed with eating disorders. Even though the work was fascinating, it was a very difficult and complex disorder to work with. Everyday I encountered young girls that did not love themselves, had distorted perception of their bodies, tried to be perfect at all times, tried to control everything surrounding them including their intake of food. It seemed like these thoughts and behaviors almost had to come from their past, yet were constantly reinforced in the present. Would it be so absurd to think that maybe part of this problem would be somewhat coming from that engrained biological reaction?

Most of these girls hear two different voices inside their head, constantly contradicting each other. One says to eat and the other says not to. It is likely that they have lost the power of their own voice in the continuous chaos between the “good” voice and the “bad” voice. One of the long-term goals for therapy would be to help them find their own voice again. My personal struggle is that I don’t know either when or why these voices started to contradict themselves, which makes me feel powerless in my helping role. These girls may also feel this powerlessness, which in turn may give increasing power to their thoughts. In order to help in these conditions it seems important to work within the context of symbols and metaphors as a way to access the

unconsciousness. These voices seem to be programmed and too loud to make sense. Therefore, an exploration of the personal and collective unconscious could help these individuals make sense of these mixed messages.

To work with Jung's concept of the personal and collective unconscious may be a way to explore these eating disorders. The core conflict seems to be well protected by these voices, which may act as a barrier blocking the path to the unconscious. In order to break down the barriers, one may need to work through unconscious processes to unfold the mysteries of the nervosa. Art making may be a way for them to concretize their inner experiences. If one can understand the voices through visual imaging one may be able to make sense of them. These girls seem to be stuck in their thinking world, subsequently they don't take time to really listen to their core selves. Words disappear in thin air; images do not. I believe that it is important for this population to resolve these issues in the most concrete way possible, and therefore verbal therapy may not be the best approach. Ehrenzweig (1967) says:

The process of image making involves tapping some inner reality of the person and therefore some expression of unconscious processes... There is an obvious difference, which lies in the fact that art activity is a conscious process, which gives concrete form to feelings, which are often unconscious. (p.51)

In reason of this, art therapy seems to be one of the best therapeutic interventions for the population in question. Art therapy offers a non-threatening approach based on non-verbal communication that allows the clients to go at their own pace. Through symbols and metaphor, one can tell their story without feeling vulnerable in front of the therapist.

I have learned through the exploration of my collective and personal existence that we all have a history: A personal history and a collective history that defines our identity as human beings. Perhaps by acknowledging this possibility some questions may finally be answered. I believe that the personal unconscious responds and reacts to the collective unconscious. Therefore, it seems important to explore the personal unconscious and its roots to help explore the acting-out behaviors of the present.

The purpose of this study is to explore the acting-out behaviors, that of anorexia nervosa (AN). The investigation of personal unconscious manifestations will thus be of main interest. Even though the collective unconscious seems to be of great value to help resolve core issues, it will not be addressed in depth in reason that it reaches beyond the scope of this research. However, interpretations and analysis of the artwork may show traces of the collective unconscious. Even though research, indicates that this disorder occurs in both gender, this paper will focus on females only. For reasons that my clients were all female and that the prevalence studies show that 90-96% of individuals living with AN are female (American Psychiatric Association [APA], 1994; Stice, 1994).

This research will take the form of a single descriptive case study. It will focus on the exploration of interpersonal dynamics and personal unconscious in the context of art therapy. This research will also explore every phase of the art therapy process of a young girl diagnosed with AN. From the artwork and case material, interpretations and links will be founded on the existing literature.

Chapter 1 -Anorexia Nervosa in Adolescence

1.1. Anorexia Nervosa

AN is a very interesting and challenging disorder to study; however, it seems to be one of the most difficult and complex disorders to treat. Patients struggling with AN often do not know or simply repress the reasons behind the disorder making diagnosis and treatment very difficult. It seems important to have a very good understanding of the different theories in order for the therapist to have insight and to be successful in his or her helping role. Furthermore, the hidden aspects of the disorder should also be explored through different means such as interpretation in art therapy. The literature indicates that the reasons for anorectic thoughts and behaviors can emerge from various sources. It seems like the underlying issues for individuals living with AN come from the past, yet the symptoms of these unidentified reasons are constantly reinforced in the present. It only seems natural to help this population make sense of their past in order to help them understand their present experiences.

1.1.1. Diagnostic Features

According to the American Psychiatric Association (1994), “the essential features of anorexia nervosa are that the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. In addition, postmenarcheal females with this disorder are amenorrheic” (p.539). The four diagnostic criteria identified are: “refusal to maintain body weight at or above a minimally normal weight for age and

height; intense fear of gaining weight or becoming fat, even though underweight; disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight and; in postmenarcheal females, amenorrhea" (p.544-545).

1.1.2. Analytic Perspective of Diagnostic Features

Art therapist, or perhaps doctors or psychiatrists may get used to the textbook definition of AN and somehow lose the complex meaning underlying the psychiatric terminology. Reading this definition as a woman trying to understand other women, it becomes much more than words used as a diagnostic tool. It becomes real and alarming. Throughout this research I have read this definition many times without realizing the impact this disorder has on the human body. Suffering from AN seems to be very "unnatural", thus far very familiar and "normal" to live with some of these described characteristics. From my own experience, I have been surrounded by people, mostly women, who have been experiencing and suffering in silence, at various levels, some form of eating disorder in order to achieve the "relentless pursuit of thinness" (Bruch, 1973, p.294).

Paying particular attention to the words that describe AN allows us to emphasize the importance of the definition. A person suffering from anorexia nervosa "refuses to maintain a minimally normal body weight, is intensely AFRAID of gaining weight, and exhibits a significant disturbance in the PERCEPTION of the shape or size of his or her body." (APA, 1994, p.539) In other words, an individual living with AN refuses the nature of a healthy body weight for his or her own body structure in order to overcome

his and her FEAR to be PERCEIVED differently. “In addition, POSTMENARCHEAL females with this disorder are AMENORRHEIC.” (APA, 1994, p.539) This means, that girls who have reached the age of the normal developmental stage of MENSTRUAL MATURITY do not or no longer experience their MENSTRUAL PERIOD.

With a careful understanding of this definition, by dissecting every fragment and bringing meaning to a scientific definition, one could easily interpret this definition or this disorder as the fear of attaining full maturity, to stop ones development, an intense fear of attaining a healthy grown-up body and refusing women hood. Many theories, which will be discussed later in this chapter, support this analytic perspective.

1.1.3. Prevalence

Leichner, Arnett, Rallo, Srilcomesuaran & Vulcano (1986) have found that 1% of Canadian female adolescents meet the diagnostic criteria for anorexia nervosa. Death from anorexia nervosa is over 10% (APA, 1994). It has also been found that 90-96% of patients diagnosed with anorexia nervosa are female (APA, 1994; Stice, 1994).

Prevalence studies have found that 0.5% - 1% female in late adolescence and early adulthood meets full Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for anorexia nervosa (APA, 1994). However, several studies have indicated that even though one is not diagnosed within the DSM-IV criteria for anorexia nervosa, aggressive methods of weight control are frequently used among female adolescents (Phelps, Augustyniak, Nelson & Nathanson, 1997; Phelps, Andrea, & Rizzo, 1994; Bunnell, Shenker, Nussbaum, Jacobson, Cooper, & Phil, 1990). Female children as young as nine years old have reported their concerns about their fear of becoming

overweight (Thelan, Powell, Lawrence & Kuhnert, 1992). These worrisome findings show a need to adopt and develop new efficient treatment methods, as well as prevention plans, in order to address this specific population's needs.

1.1.4. Physiological Consequences

AN remains an enigma to all that are touched by it and is classified by many as a psychiatric disorder. The classification of AN as a psychiatric disorder, may veil the serious physiological consequences of the malady itself and thus, seems somewhat paradoxical. In other words, AN may begin as a psychiatric ailment but gradually transforms itself into serious physiological complications. The literature suggests that these physiological complications are physical signs and symptoms of AN, however one may simply suggest that they are part of this mysterious disorder. For instance, there are probably many psychological signs and symptoms announcing the disorder before there are any signs and symptoms of physiological damage. The physical and physiological effects of AN, are simply more visible and thus measurable, than the psyche. Hence, the appearance of physical and physiological signs and symptoms indicates a late diagnosis of the disorder.

AN is a dangerous and potentially deadly disorder, and amongst psychiatric disorders has the highest mortality rate (Krantz & Mehler, 2004). Adequate nutrition is crucial, especially during adolescence in order to achieve normal adult size and reproductive capacity (Seidenfeld, Sosin & Rickert, 2004). Persistent anorexia eventually leads to serious physical and physiological problems relating both to starvation and to other methods employed to purge food. AN may thus be complicated

by osteoporosis (due to reduced intake of calcium and estrogen secretion); anemia; impaired renal function (due to severe dehydration and hypokalemia); deficiencies in essential vitamins, minerals and electrolytes; hypoglycemia; endocrine abnormalities and potentially serious alterations in cardiovascular function (severe hypotension, arrhythmias) (APA, 1994; Misra et al, 2004). Whether AN is fashionable, due to brain dysfunction or some other cause, the severity of the disorder is real. Fortunately, many medical complications presented with AN are reversible if the body weight is restored in a timely manner (Krantz & Mehler, 2004).

1.2. Etiology of Anorexia Nervosa

Understanding the etiology of AN seems to be far more complex than treating the symptoms. The urgency of the health issues constantly reinforces the need to have a quick solution. Therapist, doctors or psychiatrists tend to focus on eliminating the physiological symptoms in order for patients to be healthy again. Good intentions can somewhat mislead the treatment. Many theories have been developed over the years, however it is very difficult to find one cause for all. Unfortunately, the true etiology of AN remains to date unknown. The disorder itself may be a symptom of far more complex psychological issues.

1.2.1 Existing Theories

Many theorists believe that eating disorders have been recognized for centuries. It is known that in the late 1600's, an English physician named Richard Morton, first described the syndrome of AN. However it is only by the late 1800's, almost 200 years

later, that this particular disorder was given a specific name. In 1873, Sir William Gull's female patients showed various symptoms such as emaciation, amenorrhea, constipation, slow pulse, and overactivity (Andreasen & Black, 2001). This time lapse from discovering symptoms to being an official disorder could indicate some evidence of the scarcity of the disorder in that time. Considering the dangerous and fatal faith of this disorder, it would only seem natural that more cases would have been treated and documented, which would have led to an earlier discovery of this disorder. The very nature of AN, enhances the enigma of the etiology; its secrecy, controversy and the lack and ambivalence of information makes it very difficult to coin its appearance. Some theorists say AN is more common in this era because higher public awareness has led to increased recognition. Furthermore, the availability of treatment could have increased the need to seek help. It is also possible that education and the availability of treatment has led to increased diagnosis of AN.

Gordon (1990) states that AN is the syndrome of the new era. Perhaps it did become "fashionable" to have anorexia. The fashion industry has sensationalized the thin and emaciated female body; a silhouette that can only belong to a young adolescent girl not that of a true mature and healthy woman. In the past, many women have suffered in silence without any relief from their grief and pain. With no legal rights and very little control over their environments, the voices of the women were silenced. Could women's history actually be part of the etiology?

Gordon (1990) explains AN as an ethnic disorder reflecting human nature in conflict with the "changing times". It was found that in the 1870's "psychiatrists instructed residents that it would be unusual to see more than a small number of cases in

the course of a lifetime” (p.2). AN was known by the media to be the “psychiatric disorder of the 80’s” (p.2), and that it could easily become fashionable. Nevertheless the prevalence was still increasing. Gordon (1990) focuses not only on the clinical aspect of the disorder but emphasizes on the cultural influences. “Eating disorders have become a critical expression of dilemmas of the female identity of our own time, in a period of very significant cultural transition for women” (p.5). Furthermore, he explains the concepts of dieting, thinness and food control as cultural preoccupations that are used as defense mechanisms that enable the individual suffering from eating disorders to escape from unmanageable personal distress. He also believes that the underlying issues concerning personal distress, revolves around a sense of identity. Gordon (1990) says:

Eating disorders are also ultimately political, since they are so closely connected with the issue of the control of the female body and the conformation to prevailing standards of beauty... eating disorders partake in sexual politics, and they have also been taken up in the name of the feminist cause. (p.11)

Erikson (as cited in Feist, & Feist, 1998) defines the period of adolescence as one of the most crucial developmental stages. Firm ego strength must be achieved by the end of this particular stage in order to emerge into adulthood. The major “crisis” (or developmental issue) that needs resolution in this stage is that of identity vs. identity confusion. This crisis manifests itself from the stages of infancy throughout the course of life. However, it climaxes during adolescence as young individuals strive to discover their personal, sexual, ideological and occupational selves in order to develop a good sense of identity and emerge into adulthood. Identity formation involves various ideological experimentations that help establish a clear sense of who one is and how one

fits into this world. Some adolescents may find this particular “crisis” overwhelming because of the various possibilities that life offers to them. Therefore, they would remain in the crisis of identity confusion until they resolve the underlying issues. For some, unsuccessful adaptation of previous stages of development could be the cause of this identity confusion. For others, the inability to handle the responsibility of choices could also lead to identity confusion (Erikson, 1968). Identity confusion is defined as a “syndrom of problems that includes a divided self-image, an inability to establish intimacy, a sense of time urgency, a lack of concentration on required tasks, and a rejection of family or community standards” (Erikson, as cited in Feist, & Feist, 1998, p.243). Identity confusion has an important role in identity formation. However, too much confusion can lead to pathological adjustment, which in turn could cause regression to earlier stages of development. Consequently, responsibilities of adulthood are not properly followed through.

Erikson’s theory (as cited in Feist, & Feist, 1998) also states that fidelity is the “basic strength” developed in adolescence. Fidelity is usually achieved from the resolution of the identity crisis. However, if the crisis is not resolved properly, one may develop its pathological counterpart that is role repudiation. The significance of this term is the “inability to synthesize various self-images and values into a workable identity” (Erikson, as cited in Feist, & Feist, 1998, p. 243). It can take the form of diffidence, which is defined as: “an extreme lack of self-trust or self-confidence and is expressed as shyness or hesitancy to express oneself.” (Erikson, as cited in Feist, & Feist, 1998, p.243) or defiance, which signifies rebellious behavior against authority figures (Erikson, as cited in Feist, & Feist, 1998). The former would suggest that AN may emerge from an

unresolved identity vs. identity confusion crisis. Therefore, an identity formation gone wrong could generate psychopathology. However, historical and sociological conditions, family experiences and biological predispositions, could also fuel the development of AN. Therefore, the identity confusion alone may not trigger the disorder. Thus, therapy must help bring this stage to resolution and help discover other factors that may also need resolution.

1.2.2. Treatment

Individuals diagnosed with an eating disorder often seem disconnected from their inner worlds of emotions and feelings (Bruch, 1962; Kaplan, 2002) or may feel dominated and overwhelmed by their emotional lives (Bruch, 1978). de Groot and Rodin (1998) suggest that the focus of psychotherapy should be based on subjective experience and that for individuals diagnosed with AN, nonverbal communication can be an important resource to help describe this experience. Since experiential therapies offer a nonverbal approach to therapy (Case & Dalley, 1992), it only seems logical and appropriate to explore these non-traditional therapies in order to be able to adapt them for this population's benefit. Kaplan (2002) supports this by encouraging the use of expressive therapies with this population. He states that these therapies offer more direct access to unconscious and symbolic processes and to internal experiences of the body. If this population's reason of struggle is on the level of unconsciousness, perhaps the expressive therapies can help uncover the inner chaos and help generate meaning, order and healing for these individuals.

According to Case and Dalley (1992), “Art therapy involves the use of different art media through which a patient can express and work through the issues and concerns that have brought him or her into therapy.” (p. 1). These authors also suggest that the image is seen as a personal statement from the patient, which provides a focus for discussion, analysis and self-evaluation in therapy. Edwards (1987) states that in Jungian analytic art therapy, the image is described as an extension of the personality and as an independent entity that encompass both past and future aspects. In a patient-centered therapy, Edwards (1987) says that Jung believed that in order for image interpretation to be successful it had to be based on a mutual and understanding dialogue between the patient and the therapist. A successful interpretation can help reveal unconscious personal and archetypal material, which can be worked through in therapy.

Art therapy research with individuals dealing with eating disorders is scarce. However, the existing studies show interesting results regarding this particular population. Chafe (1995) looks at the many aspects concerning art therapy with people living with AN. With a feminist perspective, Chafe mostly focuses on sex-role socialization, cultural gender stereotypes, and public self-consciousness. She looks at the different etiological theories and family systems in order to help answer the difficult question of why women develop AN 95% (Murphy, 1984) of the time over men.

Chafe realizes that no two individuals with AN are alike; therefore the causes of this disorder are not likely to be generalized. However, throughout her research of the literature she found that certain aspects in the process of treating AN are alike. For instance, some studies suggest the use of common themes in the artwork among individuals living with AN. Crowl (1980) found that thin, child-like figures are often

depicted to represent the self-image of the anorectic individual. Waller (as cited in Murphy, 1984) found that images such as whirlpools and bottomless pits tend to be present in the early stages of the art therapy. Schavarien (1989) suggests the presence of food in the first images produced so as to test the therapist's reaction towards food. Another similarity that occurs within this population is the kind of art media used. Individuals diagnosed with AN tend to use more controllable media and they show rather compulsive and restrictive methods of work (Crowl, 1980).

In another study, Chafe (1996) used a quantifiable phenomenological approach to art therapy with a young woman diagnosed with AN. The purpose of her study was to have a better understanding of this disorder in art therapy. Chafe believed that this understanding could be established through analysis of this population's subjective experience of art therapy. Through the means of an interview outside the therapeutic frame, the results suggested that art therapy facilitated the development of ego strength (Chafe, 1996).

Harnden (1995) wrote a paper on the therapeutic process of an art and drama therapy group treated for AN. This author says that the core issue underlying the disorder of AN is the failure in the parent-child relationship to attain a healthy separation-individuation process. In her study, Harnden utilized the mirroring technique and was able to provide a good holding environment so to help the client experience a healthy separation during termination in art therapy.

Woodman (1980) explores the various aspects of eating disorders within the psychoanalytic perspective. Her research mostly focuses on a theoretical understanding of people living with obesity and searching to find the root of the disorder. It is important

to acknowledge how these theories relate to anorexia and bulimia nervosa. It seems like the underlying core issues of these disorders are very similar. Woodman (1980) seems to support the hypothesis that a communication with the unconscious needs to be established for the body to experience healing and with this communication the feminine spirit can be released.

1.3. Summary

The first chapter has presented different theories, hypotheses and assumptions related to AN which all have some truth to them. As it was discussed earlier, some theories say the cause lies in the change of times as a changing female identity, other theories say the problem emerges from the family dynamics; parents not knowing how to empower their children, some say it is due to an unhealthy parent-child separation-individuation process. Other theories show that this disorder could emerge from a lack of conflict resolution during certain developmental stages, more importantly, during adolescence creating identity confusion. However complicated and overwhelming these theories seem there seems to be truth in all of them. They seem to make sense, however while reading, analyzing and discussing with peers, certain questions always surface and bring doubt whether to support one more than the other. Could it be possible that the complexity of this disorder comes from a combination of these theories? It seems one very important fact could be that we try to generalize the causality. Each individual with AN seems to have their own story and each experience it differently even though the diagnostic symptoms are alike. Perhaps the disorder of AN is the symptom of something much deeper.

Chapter 2 – Psychoanalytic Approach and Art Therapy

2.1. General Jungian Concepts

Jung's theory of the personality is based on the notion that the psyche is composed of two levels of consciousness: the conscious and the unconscious. The conscious is described as mental images that are sensed by the ego and plays a relatively minor role in Jungian theory. The unconscious is referred as the part of the psyche that adds depth and completeness to personality. It is composed of the personal and collective unconscious. The personal unconscious is like a reservoir of all repressed, forgotten, or subliminally perceived experiences of the individual in question, whereas the collective unconscious is the deepest level of the psyche containing the inherited experiences of human and pre-human species (Jung, as cited in Feist, & Feist, 1998). According to Jung (as cited in Feist, & Feist, 1998), these experiences form the basis of the personality, and we do not remember them nor are we aware of them or have images of them. The collective unconscious can however be unveiled through the personal unconscious.

Jung believed that the psyche could not be understood by the intellect alone, it must be experienced and explored by the whole person. He therefore observed his patients, including himself, through various methods of investigation, which would help uncover manifestations of the psyche. Such methods are of word association test, dream analysis, psychotherapy and active imagination. The latter, being the major adapted method of investigation for Jungian art therapy.

2.1.1. Active Imagination

The active imagination technique could be seen as the forerunner of art therapy. Jung (as cited in Feist, & Feist, 1998) would often ask his patients who were inclined towards artistic representations, to draw or paint as a way to express the progression of their fantasies. However, this was a variation of the original active imagination method of therapeutic investigation. Active imagination required a person to imagine an impression. Whether it was a dream image, a vision, a picture or a fantasy, Jung would help his patients to concentrate on these images until they could visualize animation. Once this phenomenon occurred he asked the patients to follow their active imagination wherever it lead and to acknowledge their existence and to communicate with them. The purpose of this technique was to help reveal unconscious manifestations through symbolic images. Jung also believed that active imagination was more powerful than dream analysis because the images constructed during conscious processes were clearer and more reproducible than unconscious manifestations, and the feelings were more discernable.

2.1.2. Archetypes

According to Jung (as cited in Feist, & Feist, 1998):

Archetypes are ancient or archaic images that derive from the collective unconscious. They are similar to complexes in that they are emotionally toned collections of associated images. But whereas complexes are individualized and make up the contents of the personal unconscious, archetypes are generalized and form the contents of the collective unconscious. (p. 66)

Archetypes are biologically determined manifestations. They are not considered as inherited ideas. Archetypes are known as “mentally expressed instincts” (Jung, as cited in Feist, & Feist, 1998, p.188). It is important to distinguish archetypes from instincts. Instincts are manifested through physiological urges, which are expressed through our senses. One can become consciously aware of his or her instincts whereas archetypes are expressed through one’s fantasies in which symbolic images are their only vehicle to consciousness. The body does not sense their presence as it does for instincts.

“Archetypes characterize ways of experiencing, while the instincts typify ways of acting” (Brun, 1993, p. 5). Consequently, archetypes are biologically determined manifestations of our ancestors’ reoccurring experiences. These archetypes take the form of images in which the symbolic meaning is unconscious.

Every individual has the potential to activate these archetypes when their personal experiences corresponds to their inherited latent unconscious images, which are already existent within the psyche. Once these archetypes are activated, most likely they will influence one’s personal life. These archetypes are usually unconscious, therefore will find recognition or representation through dreams, fantasies and delusions. Only few archetypes are known enough to be distinguished and given names. These archetypes include the persona, shadow, anima, animus, great mother, old wise man, hero and the self. For the purpose of this paper, only the archetypes relevant to the case study will be discussed and described in the third chapter.

2.1.3. The Meaning of Symbols

“A symbol is a way of indirectly, but figuratively representing something else, i.e. in psychoanalytic terms an unconscious idea, conflict or wish. Symbolization is one of the primary processes governing unconscious thinking” (Case & Dalley, 1992, p.251). Symbols have a strong impact on the individual because they stimulate imagination that in turn stimulates feelings and emotions (Holbek, 1987). Jung (as cited in Rubin, 1987) says that an image is symbolic when the symbol induces strong affects in the patient. In fairy tales the symbols appear as individuals, objects and events (Brun, 1993). A symbol is an image that encompasses a meaning, which is usually unconscious to its subject. Jung describes this phenomenon: “the psyche spontaneously produces symbols when the intellect is at a loss and cannot cope with an inner or outer situation” (Jung, as cited in Samuels, 1985; p. 94). This symbol expresses a conflict in a way that helps find resolution (Jung, as cited in Samuels, 1985). Hubback (1969) says:

A symbol is being used as a descriptive word for an idea, thing, action or event representing in the present any such item, which existed previously. The item in the past is, as a result of repression, relatively unknown in the present; the symbol is, at the time of its occurrence, the best possible representation. (p. 39)

Hubback (1969) also makes an important point that the symbols that surface in therapy need discerning and understanding in order to find its true meaning. It is one of the therapist’s responsibilities to explore and find this meaning. For the discovery of the symbol’s meaning will help the uncovering of the patient’s story, which is perhaps unconscious to the patient. Another important aspect to symbolism is the phenomenon of identification. Jones (as cited in Milner, 1955) states that the process of identification is

not only the result of wish fulfillments, but is also the need to establish a relation with reality. The symbol formation could also be conscious to its subject; however the individual may have the need to hide its objectionable unconscious meaning. Therefore, patients may use symbols to represent something they wish to keep hidden from their entourage.

2.2. Jungian Concepts Applied to Art Therapy

Edwards and Wallace are the two major figures that developed the Jungian approach to art therapy. Their aim is mostly patient-centred and they see image making as a means to access the psyche. In other words, images help bring the unconscious to consciousness. Their main therapeutic goal is for the client to know and to understand the meaning of his/her images and to take the consequences of them. Edwards (1987) and Wallace (1987) both believe that transference usually takes place within the art. Having a triangular shaped interaction; patient-art-therapist, the art, in most cases, works as the mediator of expression. The counter-transference can also be dealt through the art. Edwards and Wallace both use active imagination as a means of investigation and they use it in very similar ways.

In a Jungian approach to art therapy, the image is usually seen as an extension of the personality and as an independent entity, having both a past and a future. The diagnosis and interpretation of a symbol is seen as tentative and relative since it is believed that symbols are beyond full intellectual comprehension. Interpretations are to be mutual understandings and insights between patient and therapist. It is comprehended as a synthesis of personal and archetypal material.

As mentioned earlier, the active imagination is the means of investigation adopted by Jungian art therapists. It is seen as a whole, meaning that the entire process of imagination in art therapy is acted out into the form of art. The images are processed through the unconscious and submerge into the conscious and then are acted out in artistic expression. Images are considered to have a life of their own and the symbolic events develop according to their own logic. The active imagination is where the individual begins to pick up messages from the unconscious. It is also known to develop as a relationship between the image and its maker, which stimulates imaginative inquiry and dialogue.

During the image making, a close dialogue takes place through the image and the maker. The whole process of dialogue develops into a story that needs unfolding. In other words, this story carries an unconscious message that needs to be discovered. Throughout the whole process, distance becomes a very important aspect. Jungian art therapy brings about the great significance to the process of looking. There are three steps to looking: the looking, the noticing and the seeing. As the art maker finishes his/her artwork, the distance created gets broader as to acknowledge the « otherness ». The image created is known to have a personality of its own, which may not be immediately likeable, therefore brings about this quality of « otherness ». Therefore, the client doesn't always want to take on the qualities that he or she has attributed to the art. Therefore, the client doesn't want to relate him or her self to the art produced, so he or she treats it as « not belonging to him or her » or as « otherness ». In order to have successful therapeutic results, one eventually needs to acknowledge the art as a representation of her self. Gradually the inner experience becomes outer experience and

the whole of this process is worked through the art making. The outer image is both a statement about and a personification of what was inner. It is through the stages of looking, noticing, and seeing of the images that one gets closer to the therapeutic goals.

2.3. Fairy Tales used as a Therapeutic Tool

Thompson (as cited in Brun, 1993) defines a fairy tale as:

A tale of some length involving a succession of motifs or episodes. It moves in an unreal world without definite locality and definite characters, and is filled with the marvelous. In this never never land humble heroes kill adversaries, succeed to kingdoms and marry princesses. The fairy tale is a poetical vision of the human being and its relation to the world. (p. 18)

Von Franz (1996) puts forward a hypothesis “that every fairy tale is a relatively closed system compounding one essential psychological meaning, which is expressed in a series of symbolic pictures and events and is discoverable in these.” (p. 2)

According to Thompson (as cited in Brun, 1993) “the fairy tale is a poetical vision of the human being and its relation to the world” (p.18). In fairy tales much of the individual’s wish fulfillment are expressed openly; it projects the relief of all inner pressures, offers solutions and promises a happy ending (Bettleheim, 1989). “Fairy tales are the purest and simplest expression of the collective unconscious psyche processes” (von Franz, 1996, p.1). And these expressions find their voices through the language of symbols (Bettleheim, 1989). Brun (1993) claims that symbols in fairy tales are very helpful. Holbeck (1987) explains that the individual’s emotions and feelings are protected by the mere fact that the symbols belong to the story. The individual’s

projections and identifications onto the fairy tale's symbols seem less threatening because of the distance the organization of the tale creates (Bettelheim, 1989). Through symbols, the individual can help explain his or her situation with a more concrete picture (Brun, 1993).

In the current literature, several research studies have been conducted on the therapeutic use of fairy tales with children (Brun, 1993; Runberg, 1993; Bettelheim, 1989; von Franz, 1997). Bettelheim (1989) expresses how important fairy tales are in the development of the child psyche. Fairy tales help the child cope with the psychological dilemmas of growing-up and the integration of their personalities. The language, images and characters are parallel to the child's level of comprehension, therefore makes it easier for the child to find comfort in fairy tales.

It is known that there are many similarities between the fairy tale and psychotherapy. Jung (as cited in Feist, & Feist, 1998) said that the anatomy of the psyche could be best studied through the use of fairy tales. According to Bettelheim (1989) fairy tales have two different purposes. The first purpose would be for entertainment and the second would be to have a direct link to the unconscious mind. He also states that the very construction of fairy tales has four essential elements that are closely related to psychotherapy. Fantasy, recovery from deep despair, escape from great danger and consolation are the founding elements of fairy tales, furthermore are important elements in psychotherapy.

Brun (1993) says the fairy tale is an important source of reference to the past because of its visual quality. The images and symbols from fairy tales help stimulate the unconscious mind. It forms a bridge between past and present, therefore facilitating the

link to childhood memories. The experience of hearing or reading the tale can arouse the senses and can trigger memories. Sometimes when feelings are difficult to talk about, one may find expression in fairy tales. Runberg (1993) says that the use of fairy tales in psychotherapy can be a gentle and non anxiety-provoking approach to reach earlier conflict material. When provided with familiar pictures from childhood, this creates a potential space to explore these unwanted difficult feelings and emotions (Smith, 1990). Fairy tales can also be used as an assessment tool to help identify inner conflicts. When a child wants to have his or her favorite fairy tale read over and over again, one might be able to determine the inner conflicts the child is experiencing. By drawing attention to a story, the child reveals something significant about himself. (Brun, 1993)

The use of fairy tales in art therapy practice may be another way to look for clues to help uncover unresolved unconscious conflicts. Thus, fairy tales could be used as an assessment tool. If similarities can be found between the individual's life experiences and his or her choice of meaningful fairy tale, then evidence would show that the therapist could assess where the conflict lies through the interpretation of the psychological content of the patient's favorite fairy tale.

2.3.1. Archetypes in Fairy Tales

Archetypes are the basis of images and characters in fairy tales. Their role seems just as important in fairy tales than in dreams. They belong to the unconscious world; however can reveal important clues to real life conflicts. Working with fairy tales, the symbols and archetypes may take the form of individuals, objects and events (Brun, 1993). The interpretation of symbols and archetypes from fairy tales depends on the

individual experiencing the tale. Many interpretations can be offered, however one must identify the relationship the fantasy has with reality. Bettelheim (1989) says that a story resonates to a particular child at a particular time depending on the child's psychological stage of development and on the problems that are experienced at the time. Therefore, an individual's meaningful fairy tale is most likely a reflection of one's life experiences and current conflicts.

Archetypes have bipolar, conflicting characteristics. Archetypes usually present themselves in contradictive characters, for instance, the good mother vs. the wicked stepmother. It seems that each archetype has an opposite character, which creates the conflict. This bipolar quality of the archetype also gives creative potential for archetypal content in fairy tales. The opposing characters are often key elements of the fairy tale.

2.4. Summary

An overview of Jungian concepts applied to art therapy is of main importance to chapter two. The psychoanalytic Jungian concepts are explored in order to help find answers to anorectic thoughts and behaviors, which will be of subject in the last chapter. The conscious and the unconscious are the two main components of the psyche, which the unconscious plays a major role in Jungian theory. The unconscious is formed of the personal and the collective unconscious. For this paper, the personal unconscious is of main interest. The well-known technique called active imagination, which could be seen as the forerunner of the art therapy approach, is also discussed. The importance of archetypes, symbols and fairy tales used as tools to access the unconscious are also investigated.

Chapter 3 – Anorexia Nervosa in Adolescence: An Exploration of the Personal Unconscious in Art Therapy

3.1. Single Descriptive Case Study: Art Used as a Method of Expression

Based on Jungian concepts, the purpose of this study is to explore the meaning of unconscious material manifested in art therapy with individuals dealing with anorexia nervosa. Throughout the literature there are many theories and hypotheses that help explain the extreme behaviours of the individuals struggling with this disorder, however the whole remains just as mysterious and complex. Symbolic interpretation of the content of the artwork done in art therapy is of main interest for this paper and could help solve the enigma of AN. Therefore, evidence to help support this approach will come from the existing literature and the case material of a young girl diagnosed with anorexia nervosa, which I have treated in art therapy during my practicum. Interpretation of the artwork from the art therapy sessions will be based on the patient's description of the art. However my own intuitive knowledge will also be of subject and important links will be based on the existing theory. The hypotheses of this study propose that the use of art in therapy could lead to a better understanding of anorexia nervosa, assuming that art could be a manifestation of unconscious processes. Because this research is a single descriptive case study, the results cannot be generalized.

3.1.1. Patient Identification

The participant for this research is an outpatient adolescent girl diagnosed with anorexia nervosa. She is 14 years old attending a private school and is an only child,

living with both her parents. From an urban teaching children's hospital, her physician referred her for individual art therapy. As part of her treatment, her physician and art therapist (in training) followed her weekly; the hospital dietician also met with her and the family was also referred for family therapy. In order to respect confidentiality and for the purpose of this paper, the patient will be referred to as Mary.

Family and friends seem to be very important for the patient. Mary's mother comes from Italy and she is described as the decision maker who sets the limits at home. Her father's origin is American. Mary mentioned that her father is often away on business trips and she sees him as playful and permissive. Mary likes team sports, however does not like the aspect of competition. She is spiritual rather than religious and believes in the good of people. She likes wintertime and evenings and also likes arts and creative writing. As many adolescents of her age, Mary's interests in dating seem to be emerging.

3.1.2. Agency

This case study is based on art therapy sessions of a young girl diagnosed with AN. This patient was referred from an adolescent clinic from a children's hospital. This hospital is committed to a teaching setting and teamwork. Communication between the staff is an important aspect and is crucial to provide the necessary care for the patients. The physicians are usually responsible to refer the patients to the interns, but sometimes the social worker or the nurses may also give referrals. The patients referred can be either in or out patients. The physicians are usually good at recognizing the need for psychological care along with the medical treatment. The team seems to have an open

attitude towards art therapy and values the importance of our work. My on-site supervisor is an established art therapist and is part of this team. The population treated at this hospital is children and adolescents no older than 18 years of age. My caseload mostly consisted of eating disorders such as anorexia, bulimia and overeating.

3.1.3. Facilities

A fairly small conference room was used for the art therapy sessions.

Considering the limited amount of space at the clinic, we were fortunate to be able to use the same room most of the time. However, two of our sessions took place in the physician's examination room. The conference room was not the best possible facility to do art therapy; however by keeping a constant framework we were able to establish a good therapeutic relationship. It is important to create a comfortable atmosphere in order to overcome the disadvantages of the facility. When I first learned that the physicians' conference room was going to be used for art therapy, I was really concerned of the effect this would have on the therapeutic intervention. According to Case and Dalley (1992), "each art therapy room will be formed by the forces within it and outside it."(p.32).

Therefore this meant that I had an important role on how the room would be experienced by the patient. With a little creativity, humor and playfulness it seems I was able to make that room comfortable enough for the patient to engage in art therapy. The art therapy room plays an important role within the sessions and everything within it and surrounding it can be used for projection through creative imagination. The environment in which therapy happens needs to stimulate and be considered as a different space, special and safe for the client to express his/her inner feelings. It is also thought that

good conditions of work, even if the room is not ideal, can still reach the therapeutic goals (Case & Dalley, 1992).

3.1.4. Art Supplies

The presentation of the art supplies was also taken into consideration. I always made sure that the art supplies were set up in the same way, at the patient's full disposition, in her field of vision. Although a good selection of art supplies was provided, it was somewhat limited since it had to be convenient to transport from room to room. The supplies were stored in a small art box, which contained pencils, erasers, crayons, felt pens, oil pastels, tempera paints, watercolors, sparkle glue and self-hardening clay. Another important tool in art therapy is the collage box. The collage box is a selection of cut out images from various magazines and books, which the patients can utilize for their artwork. A selection of various sizes of paper was also provided. According to Rubin (1978), the art therapy room should have a good selection of art materials that is appropriate for the client. I believe that the art supplies mentioned above do fit those criteria. It is known that individuals living with anorexia nervosa have a tendency towards perfectionism and in order to achieve this perfection in art therapy, these individuals often do art in pencil and use erasers very often, which can result in economical (very much controlled and clean) drawings. Therefore, the therapist may want to control this aspect of the therapy for this population by eliminating the eraser or both pencil and eraser. However, for this patient, the environment was not controlled. As a result, the issue would be addressed instead of being avoided. The obsessive use of

the pencil or eraser could actually encourage a discussion on perfectionism and its presence in the patient's everyday life.

3.2. Therapeutic Goals

According to Mary, her goals in therapy are to attain a normal life again, which at that time meant to do activities, to eat and to go out. These goals seem to be short-term rather than long-term. However, with art as another means of expression, Mary may be able to explore her inner world of chaos and express it in a concrete, more tangible form. By using other means to achieve emotional expression she may find her voice again and then be able to verbalize her needs in her everyday life activities. She may also discover new goals, such as being more assertive and finding new ways of relating, understanding and accepting herself.

The aetiology of anorexia nervosa is very difficult to identify. In order to begin the healing process, it only seems natural to find the source of the problem. However, if the source of the problem is disguised or repressed by the patient, how can the therapist be efficient in her helping role? Perhaps the use of art as a medium of expression could help reveal the unresolved issues that need resolution and with the use of interpretation the personal unconscious may be explored. It seems that the art process and the content of the artwork could be a manifestation of the unconscious. Therefore, with interpretation of the artwork and the art process, personal unconscious manifestations can be explored and may help discover new meanings and understandings for Mary.

3.2.1. The Art Therapy Approach and Techniques Used

This case study will focus on exploring the interpersonal dynamic and personal unconscious of the participant in the context of art therapy. Every phase of the art therapy process, including the therapeutic alliance, the resistance, the problematic, and the termination will also be explored. From the artwork and case material, the researcher will base her interpretations on the existing literature. For the scope of this research, the transference and counter-transference will not be included even though these manifestations were present in the art therapy sessions.

The art therapy sessions were scheduled once a week, 45 minutes a session, using art as a medium of expression. With the patient's full consent, I was given the permission to reproduce the artwork and use the case material for this research. As her art therapist (in training) first and researcher second, it was indicated that no reference would be made to her identity and that at all times confidentiality would be respected. The patient was also told that her consent could be withdrawn at anytime without her treatment being affected.

At the beginning of each art therapy session, we would talk about the happenings of her week including her thoughts, feelings and emotions. Then, it was suggested she express and represent these in her artwork. I gave her the space she needed to explore her feelings and emotions that she did not necessarily have at home. I tried to be the person who listens, respects, encourages and understands her without judgment and by not adopting the role of the rescuer.

3.3. Description of the Art Therapy Sessions

Often it is known that patients struggling with anorexia nervosa tend to rationalize their thoughts and behaviors and they have trouble addressing their feelings. The core conflict seems to be buried deep inside. Therefore, they may need a rather concrete way to explore their inner feelings. Art may become a significant tool to help them explore their inner world. The artwork can also serve as a visual document of the art therapy sessions, which can be very useful for mid-term and end revisions.

3.3.1. Establishing the Therapeutic Alliance

For the first six art therapy sessions, the main goal was to establish a good therapeutic alliance or working alliance (Weiner, 1998). Bordin (as cited in Weiner, 1998) described the working alliance as “(a) a mutual understanding and agreement between patient and therapist concerning the goals of the therapy, (b) a shared commitment to the treatment tasks necessary to achieve these goals, and (c) a sufficient bond of attachment between them to sustain their collaboration in resolving strains that inevitably arise during the course of therapy.” (p.35-36). It is said that the stronger the working alliance, the greater the chance to have successful therapeutic results. In order to establish an effective therapeutic relationship, the therapist has to develop good skills in communicating warmth, genuineness, and empathy (Weiner, 1998). According to Aach-Feldman and Kunkle-Miller (1987), “the first step in any therapeutic relationship is the establishment of trust” (p.269) which is usually the result of a successful therapeutic alliance.

Our first session followed what seemed like an unpleasant doctor's appointment. Mary was just told that she had to be home hospitalized. Bed-rest and absolutely no activities were prescribed because of her weakened physical state of being. Mary seemed to be disappointed; however her emotions seemed to differ. Even though Mary seemed to be crying, interestingly no tears were secreting from her eyes. One of her main concerns seemed to be her parent's reaction to this news. Her mother was present at the doctor's appointment and she seemed very supportive and concerned about Mary's condition. Whereas Mary's father was gone for the week on business and Mary was worried that he might be sad and disappointed that she was in this situation. We discussed art therapy and her expectations during this first session. She mentioned she liked art and creative writing. For this session I suggested, as an "ice breaker" activity that she could decorate her portfolio (where all her artwork would be stored throughout the therapy sessions). She chose to write her name meticulously in big, thick letters using an HB pencil, eraser and paint. She also asked for a ruler, which was not provided. This was not controlled intentionally. However, we were able to discuss the use of a ruler and her concerns for not having one at her disposition. The last ten minutes of the sessions, a quick drawing of her feelings was suggested (see Figure 1). She drew a picture of herself standing at the bottom of a mountain, wearing a broken heart on her shirt. Interestingly, her goals (to be normal again, to do activities, to eat and to go out) were resting at the top of this mountain. She said these goals were attainable but nonetheless hard and then titled this first session "Relief". She explained the choice of her title by describing her state of being. She felt relieved to be able to talk and debrief about the doctor's prescription. However, I wonder what this title could signify on an unconscious level.

Could she be relieved that finally someone had listened and realized how much she was in need? Was she relieved to have the constraints of everyday life taken away from her for a week? Or was she relieved that her parents would finally see how miserable she really was? Perhaps she was relieved that this secret was no longer hidden? These assumptions will constantly be investigated throughout the treatment.

During the first few sessions, the content of our discussions was mostly about “Getting to Know You” (title of the second session) and gathering leading information on Mary’s family and on her emotional state of being. For instance, during our second session, Mary sculpted a snowman out of clay. It was suggested she engage in a dialogue with the snowman, since unconscious manifestations will most likely surface during spontaneous dialogue between the image and its maker. McNiff (1992) believes that talking “about” an image usually is a discussion governed by the conscious ego, which controls its contents. Whereas talking “with” an image or creating a dialogue with an image, “is based on the acceptance of the autonomous life of pictures within a world of interactions and multiple perspectives” (p. 105). This process helps the image-maker acknowledge various perspectives that are inspired by the image, yet are expressed by its maker. From a therapeutic perspective one could analyze or see this dialogue as a projective technique. According to the projective technique hypothesis, the patient will most likely reveal internal structures that shape his or her responses to the outside world, often in symbolic representation (e.g. snowman) (Feder and Feder, 1998). For instance, Mary seemed to be uncomfortable to engage in an imaginary conversation with her clay snowman, however she was able to imagine what he was saying, “I am alone outside and I am cold”, and she added that the snowman was happy. This description seemed to have

a contradictive message. Being cold and lonely usually does not equal happiness. From a psychoanalytic perspective, it is possible that Mary projected her own thoughts and feelings onto the snowman. Perhaps she was feeling cold and lonely but felt the external pressures to put on a happy face. The snowman's words could also represent Mary's ambivalence towards therapy and treatment for her eating disorder. For instance, it is quite possible that Mary was happy to meet with me even though she had feelings of resistance.

During these sessions, she also mentioned that the most important things in her life are family and friends. She also said she had a hard time dealing with discord; therefore I assume she is the compliant type. As we will see from her drawings, the theme of happiness will frequently be present.

From our third session, I got a first glance at the family dynamic. Using a pencil and eraser, it was suggested Mary draw her family doing an activity (see Figure 2). During the making of the artwork, Mary seemed to be expressing a little frustration towards drawing the correct representation of her father. She erased his face numerous times, stating that he always looked like a boy rather than an adult. This seemed to be an interesting theme to explore. When we discussed it, Mary explained it by referring to her mother as the parent who sets the limits and does most of the discipline, whereas her father being more permissive and playful. Mary's struggle to draw a mature father has an interesting link to the description of her father's role at home. The drawing itself gives the viewer an idea of the family portrait. For instance, Mary's father stands in the middle, separating mother and daughter. Interestingly enough, this theme will surface again later in therapy. Even though Mary's description of the image is of her family

walking the dog, this image seems very still. No movement is noticeable and interestingly the figures are cartoon like. It was found that an individual living with AN is often reluctant in representing humans in their drawings (Wadden, as cited in Murphy, 1984). It seems like Mary's cartoon like figures would support this idea.

In our fourth session, Mary mentioned family therapy and that her family therapist asked many questions about the past. Mary said she did not like to talk about the past (when her situation was "bad"). Mary said it was too hard for her at the moment to look back. She wanted to focus on feeling and getting better. When we explored this a little further she said she did not want to find out what happened that brought on her anorexia. Mary seemed hesitant and showed difficulty in articulating the word anorexia.

Once this discussion was over, it was suggested she "draw a bird's nest", which is used as an assessment tool to help have a better understanding on attachment. The bird's nest is assumed to serve as a maternal and protective symbol in its containing function and womblike form. It has the potential to visually portray an individual's unconscious representation of attachment. The bird's nest drawing elicits graphic indications of secure or insecure attachment. It is known to help uncover emotional issues concerning an individual's internal expectation of their relationship to family members and intimate partners (Kaiser, 1996).

This exercise seemed to be responding well to Mary's thoughts and needs since she seemed to know right away what to draw and she showed good concentration during the task (see Figure 3). She used a pencil and eraser at first. She drew mama bird and papa bird on each side of the nest. The nest was lying in the middle of a branch with leaves at the end. The nest itself takes up a fair amount of the branch. A big happy sun overlooks

the bird family and a cloud is not too far behind. Mama bird has a rigid feminine allure, dressed in pink and wearing a flower behind her ear. It seems like a melody comes from mama bird, however mama bird's beak is closed shut. Her eyes seem to be looking straight ahead in a trancelike gaze (looking through papa bird). A butterfly is flying near mama bird's ear and a heart floats in front of mama bird's chest. Papa bird has a worm in his beak, providing food for the four baby birds. Papa bird has a blue bowtie, is dressed in purple feathers and his eyes are looking over the baby birds. Papa bird seems tired. There are four baby birds in the nest, two are pink and two are blue. One blue bird is singing the same song as mama bird, his head is facing upward with its beak open appearing hungry. The other blue bird is sleeping and the two pink birds are waiting patiently. Mary titled her drawing "A Happy Family".

We also discussed the meaning of colors during this session. For Mary, dark colors signify sadness, while blue shows calmness and peacefulness. Yellow and orange mean life and brightness. When she was asked what the color red meant for her, she hesitated and then answered red is an intense color, which represent anger.

Mary worked on her bird's nest for two sessions. It seemed important for her to finish this drawing. This drawing was mostly done in silence, however when discussing the artwork, interesting themes surfaced. Sometimes in art therapy silence is important for the imagery to emerge. Therefore, the art therapist must learn to be comfortable, patient and stay in the presence of a silent patient. It is important to wait for the process to take place. (Case & Dalley, 1992)

She mentioned how the branch that holds the nest reminded her of how a family is built on a strong structure. However, in her drawing the nest does not seem very secure.

The nest could easily tip over from a strong wind or a storm, perhaps suggesting that her family could also easily fall apart. This interpretation was not shared with Mary because it seemed too early in the treatment to confront her with these issues.

Interpretation involves making conscious unconscious processes and puts the understanding of this process into words.... Images are statements that have different layers of meaning, which can only be gradually unfolded. As the image is unique to the patient, it is only she who can ultimately come to understand its full significance, and premature interpretation can easily interfere with this delicate process. (Case & Dalley, 1992, p.64-65)

Therefore, it is important for the art therapist to be patient and to wait for the patient's readiness. Levens (1987) compares pressuring interpretation on a patient living with AN to force feeding. Needless to say, the therapist does not want to force feed his or her patients in any way.

During our discussion on the bird's nest, the question about siblings was raised. Four baby birds were in the nest; therefore it seemed appropriate to ask Mary how she felt about being an only child and if she ever wished for siblings. Interestingly, Mary said she remembered as a child, asking her mother not to have any other children in fear of losing the attention. Now, she wishes she did have younger siblings so she could play with and care for them. She also mentioned that this constant attention is overwhelming at times. Mary mentioned that during their second family therapy session she did not feel comfortable to be the main topic of conversation and to openly express her feelings and emotions in front of her parents. Again, contradiction seems to be an important factor in Mary's life. She says she feared losing attention as a child and now

as an adolescent she is not comfortable with all this attention. This behavior could be related to typical adolescent process, wanting to separate from the parents and gaining independence. However, it is of concern why a child would ask her mother not to have any other children in fear of losing the attention. This seems to suggest an insecure attachment.

With a careful look at the bird's nest drawing, one could assume this family had dysfunctional tendencies. At a first glance, the title (A Happy Family) could convince the viewer to believe this drawing is happy. The colors are pleasing to the eye, and it is assumed that if dark colors represent sadness for Mary, perhaps bright colors represent happiness. The big happy yellow sun makes everything brighter and full of life. However, Jolles (1964) found that an acute awareness of authority figure is suggested when a large sun is spontaneously drawn. Nevertheless the sun may also symbolize warmth in one's environment. This description seems to apply in Mary's case. When one pays attention to the details of the drawing, they do not necessarily show happiness. Mama bird looks rigid and papa bird looks tired and the baby birds are hungry, patient and sleepy. The colors Mary chose do not seem representative of the content, feelings and emotions of this drawing. This bird family does not look happy and the title is questionable.

The bird's nest seems to be one of the most important drawings revealing important aspects of Mary's family. We will come to see the recurring themes, which surfaced during the first five sessions, throughout the art therapy sessions. The core problem seems to be mainly coming from the family dynamic.

Important information was shared during our first five sessions. Possibly, from Mary's perspective, our first sessions were just small talk and getting to know each other. However, the information shared could be seen as important clues leading to the core issues that resulted in anorexia nervosa. From an analytic perspective, Mary seems to be the compliant type, meaning she will answer her loved one's needs before her own. It also seems like she has put on a happy face for a long time and now with her disorder being brought forth, she feels forced to face her secret self and share it with her family and therapists in order to feel better. It is also of great interest to why she would ask her mother not to have any other children. Why would a child be concerned with this? Why would having a sister or a brother take away her mother's attention, affection or love? This information indicates an insecure maternal relationship. The bird's nest drawing seems to support the latter. Mama bird seems to be detached from her family. It appears there is no emotional connection between mama bird and the baby birds or papa bird. The family dynamic from the bird's nest drawing seems to indicate an insecure maternal attachment and may result in separation-individuation conflict. Winnicott (1971) says that inadequate response to a child's needs may result in a lack of trust in the environment and in the potential space between mother and child. This may help develop a false or compliant self in the child, who has learnt to hide the true self from the pain caused by inadequate responding. It seems like the lack of trust and inadequate responding could suggest an insecure attachment relationship with the mother. This seems to be the case with Mary.

Most of her drawings were made with a pencil and eraser first and then color was added. Most of the time, she worked on her drawings for more than one session. Mary

also asked for a ruler during our first session. These details seemed to be informative on her personality. Mary seemed to have the need for control and perfectionism. Crowl (1980) found that individual with AN tend to choose more controllable media and they tend to be more compulsive and restrictive in the art making. It is suggested that excessive erasing, as observed in Mary's behavior during the second session, signifies dissatisfaction with the self in adults and adolescents (Bodwin & Bruck, 1960; Hammer, 1968). Additionally, erasing usually draws attention to the erased item and suggests conflict or concern particularly to this area.

3.3.2. The Resistance

Weiner (1998) defines resistance as a “paradoxical reluctance of patients to participate in the treatment process” (p. 154). He adds that it is important for the therapist to allow the resistance to happen in order to circumvent it, to explore it and to finally break through it. Resistance is an important part of the therapeutic process and one needs to respect it. Mary's resistance to art therapy seemed to be expressed towards the approach itself.

During a team meeting, Mary's doctor told me that Mary asked her to tell me she was not interested in doing art anymore in our sessions. Apparently they had a discussion about art therapy and Mary seemed to have doubts about this approach. It seems peculiar that Mary would not talk about this issue (which must have been important enough for her to discuss it with her doctor) directly with me. I found it interesting that she would ask someone else to talk to me in order to get what she wanted. It seems like Mary is not comfortable in confronting someone or in speaking the truth when it could displease the

person confronted. From this situation, Mary seems to avoid affirmation and confrontation.

The following session, after we discussed the holiday break, the issue about art therapy was addressed as an open-ended question. Mary said she was ready to talk now instead of drawing and did not elaborate with details. Instead of rewarding her behavior (which seemed like manipulation instead of affirmation) Mary was given the choice to express her thoughts, emotions and feelings in whichever way she felt most comfortable. The art supplies would still be at her full disposition, in case she ever changed her mind. It was explained that I was also open to verbal therapy. It seems like Mary was either questioning the art therapy approach or she may have seen something threatening in her previous artwork, or perhaps she fears that I have seen something she does not wish for me to see. Her sudden change of mind about art seems to be related to therapeutic resistance. Perhaps her last drawing was too revealing of her family dynamic and maybe this scared her. Most of the time acknowledging means change, and change can be experienced as a threat. Therefore, the treatment is challenged. "It is known that resistance to change stems from an anticipation that recovery will put an end to certain advantages of being disturbed." (Weiner, 1998; p.156) Perhaps change for an individual living with AN may enhance fearful fantasies of future results such as weight gain.

During the next few sessions, Mary talked mostly about her relationship with her mother. Mary mentioned that her eating disorder may somewhat be related to unresolved issues with her mother. However, Mary made sure I understood that she was not necessarily blaming her mother. Again, her compliant behavior comes into action. She explained that her mother's mood often influenced hers. Mary often wondered why her

mother is upset and stressed, and when Mary tries to open-up the conversation, her mother pushes her away instead of reassuring her. Then, Mary is left with the feeling of helplessness and her assumptions about her mother's behavior. Mary often believes she is responsible for her mother's bad moods.

It was suggested she express these thoughts in family therapy. Mary seemed to consider it; however she expressed her need to discuss the matter ahead of time with her father. Mary said she was afraid of the outcome and perhaps a discussion with her father would help him understand her position better before her mother had a say. Again, Mary seems to be avoiding confrontation by manipulating the situation, in fear of being rejected. Her voice is only heard through others. At the same time, by these actions, her father is put in an awkward position where he has to choose between his daughter and his wife. This seems to be fueling an unhealthy family dynamic.

After two sessions of just talking, Mary came to art therapy a little disappointed because she just learnt that she had lost weight in the last week. She asked if she could do art, emphasizing that it was not because she did not want to talk. Letting her know that she chooses what she wants to do during the sessions, she decided to do art about things she liked and things she found important in her life. Therefore, no direction was needed; Mary seemed to know what she needed to work on. As Mary was working on her art, she brought up the issue of commitment and how a person should never break their promises. She said that in her 14 years of life, she had been often disappointed because of broken promises. Indirectly, Mary was telling me she had been hurt in the past and to earn my trust that I had to be honest and straight with her. Mary also seemed curious about my role as a therapist. She asked if I was seeing any other patients and if

so, did they live with AN. She said she was curious of how others dealt with this kind of problem. Mary seemed to be questioning my abilities as a learning art therapist and perhaps she was testing my loyalty to my patients. I eased her mind by telling her I was seeing other patients with eating disorders; however I was not going to share any information concerning their case in respect of the confidentiality agreement I make with my patient. However, Mary was invited to share her thoughts and fantasies on the matter.

This conversation seems to have opened doors for Mary to talk about her disorder. According to Weiner (1998) the easing of the resistance usually encourages the emergence of thoughts and feelings, which will most likely be shared with the therapist. For the first time she explains how it is to be anorexic. Mary was able to admit that even though the most apparent symptoms are physical, that they are really more psychological and cannot be cured medically. It seemed important for her to tell me she did not bring this disorder on herself, and it seemed important for her that I believe her. Mary said she felt a lot of guilt for causing this much disruption in her family and for making her mother sad. From what Mary says, it seems like her parents do not understand her disorder. More importantly, Mary has not come to the realization yet that other people's opinions or level of understanding is not as important as her own. By the end of this session, it seemed like Mary's guards (her resistance) had come down. I felt a great connection.

The drawing of this session consisted mostly of written words in bubbled letters (see Figure 4). She worked on this drawing for three sessions in a row. Mary described these words as the most important things in her life, which are family, friends, soccer, ski and school. The only word shaded in was "family". At the end of each word three dots

were drawn, possibly suggesting continuity. Case and Dalley (1992) say that words drawn or pasted on images call for the therapist's attention. It is meant to be a signal, and the words represent something the patient wants to talk about. Therefore a title could also have revealing qualities or hidden aspects that would need further exploration.

3.3.3. Looking Closer at the Problematic

The following two sessions, Mary continued working on the previous drawing (see Figure 4). She added color and images to her drawing. In other words, she added more information. She chose two magazine images from the collage box of a father holding and caring for his baby. Those two images were pasted in each corner of the word family. On top, in the middle of the two images, Mary painted three flowers (purple, pink and blue). Interestingly, she painted a border around each image, one purple and one pink, containing father and child. She also filled-in the word friends with vibrant colors and painted a green border all around. She also pasted words from the collage box: style, naturally and "se faire inviter c'est important" (it is important to be invited). In between the words family and friends, Mary drew a heart with two arrows pointing towards each word. The word "coeur" (heart) was pasted in between the arrows. Underneath the heart, Mary painted a smiling sun with one cloud on each side.

By looking carefully at this image, one could easily see that the words family and friends are of main interest and soccer, ski and school seem to be a distraction or add-ons. No particular attention was given to these words, it seems like their role is to fill-in. Now let us focus on these two important words. The word family is shaded in black and white, whereas the word friends, is colored in bright colors. As discussed earlier, Mary

mentioned that dark colors represent sadness and we could assume happiness for bright colors. This could suggest sadness within the family. The heart in between bi-directional arrows seems to be caught in the middle of two very important aspects of Mary's life (Family and Friends). Again, the sun is present in Mary's drawing. As we have seen earlier a sun spontaneously drawn usually symbolizes an authoritative figure and interestingly it is underneath the heart and in-between two clouds and the two words. Another interesting element that will repeat itself in the following artworks is the presence of the number three. For instance the three flowers, the sun and two clouds, the heart and two arrows. This number seems to be consistently manifesting itself unconsciously in Mary's drawings. The only logical interpretation would be that the number three represents the mother, father and daughter.

During these visits, important issues were discussed. Mary talked a lot more about the family dynamic at home. She said that at home she often does not feel heard and she feels her parents are keeping a secret from her. They fear she may not be able to deal with the truth of this unshared information. However, Mary has to live with the effect this secret has on her mother's mood. Mary is left to assume and she blames herself for what is happening to her family.

Once again, Mary discussed this issue with her doctor instead of confronting her parents. Mary asked her doctor to talk with her mother about her moods. It seems like Mary always depends on others to get something from her mother. This raised important questions about her relationship with her mother. Mary always seemed either anxious or afraid when it came to addressing or confronting her mother. When Mary was asked

about her role in the family, she had no answer. Therefore, it was suggested she think about this for the next week.

The following session, Mary talked about a fight she had with her mother. She told me they were able to scream at each other and then patch things up. Mary also added that this fight seemed to serve as a good release for both of them and now it seems like things are looking better. More importantly, Mary was able to realize that the doctor's conversation with her mother had almost no effect on her mother's behavior. However, when Mary spoke-up she did get a reaction from her mother. Mary seemed proud that she was able to express her feelings towards her mother and then fix the problem herself instead of having someone else do it for her.

Apparently, Mary's parents went to a family therapy meeting without her. Mary said she did not mind this and that she actually enjoyed her time alone at home. Perhaps unconsciously, Mary thinks her parents need counseling by themselves. During this session Mary also talked about the things she wants in life. She said she would like three or two children when she is older and she also wants an honest husband. She does not like lies and secrets because it makes it hard to trust. Interestingly, Mary told me when she was a child, she was not just afraid of her parents having other children, she was also afraid of them getting a divorce. From this information, one could assume from Mary's story, that being an only child is not that wonderful and perhaps her father has not been an honest husband, by telling lies and keeping secrets. Possibly, this could be the reason behind her mother's various changes of mood.

This image seems to be reflecting every aspect we have discussed in therapy so far. It does look like family and friends are the most important aspects in Mary's life.

However, it only seems “natural” that at Mary’s age, friends become more interesting than family. The colored word “friends” and the shaded word “family” could support this opinion. Mary seems to be caught in the dilemma of choosing friends over family, the bi-directional heart seems to indicate this idea. Another interesting element is the absence of the mother. Perhaps she is unconsciously represented as one of the three flowers, but consciously there is no sign of the mother. This issue will be addressed later in the course of therapy.

Interestingly, the father’s presence is seen in the images Mary chose from the collage box. Both images seem to represent the closeness of father and baby. As mentioned earlier, Mary seems to want to say something important through the use of words. It seems like she is trying to tell her family that she is becoming an adolescent and that it is only natural to want friends other than family and that “it is important to be invited”. Perhaps the essence of the message is that she needs her family to support her in this difficult but exciting transition. This message seems to be apparent in this drawing (see Figure 4), however Mary is sharing this message with me in silence. She does not express these needs verbally and more importantly she does not express them openly with her family. I would argue that this maybe the problem. Mary has always been the good girl, the pleaser and compliant type. Mary does not want to disappoint her loved ones. Now things are changing. She is growing-up and has to gently separate from her family ties, and perhaps this is a disappointment to her parents. It seems like the family is too close and Mary’s separation-individuation process may threaten the “life” of the family.

Another artwork that could represent the closeness of the family was a valentine Mary created for herself (see Figure 5). This valentine is composed of three layered

hearts, which represents her family. Mary pointed out that the smallest heart represented her. She chose red and black, red being the two smaller hearts and black being the largest. The three hearts are glued together creating one heart. Mary added glitter to the final piece and filled-in the small heart. Then, she wrote, “Love is a many splendor thing...” On another piece of paper she wrote her valentine wish (see Figure 6): “I hope this day will be a day filled with lots of happiness. May all my problems and concerns vanish for just this one special day, hope that this day will help me keep faith and hope throughout my other difficult days.” However not openly expressed, Mary’s message seems clear. She wishes for happiness and this will only be, if her problems disappear. Interestingly, the written valentine followed the art making of the valentine itself. One could easily link them both together and assume that Mary’s problems and concerns originate from home.

The following session, Mary had brought up an interesting point of view. She talked a little of her feelings of guilt towards her disorder and that she feels selfish in the face of others who have much bigger problems. While we were exploring this issue, Mary was leafing through the collage box. She chose three images (see Figure 7): the word “colère” (anger), the word help and an image of a hieroglyph.

During this conversation, Mary mentioned she had a discussion with her mother about a challenging situation she was confronted with at school. The students at school had the privilege to dress in every day clothes for one school day and Mary was very uncomfortable with this. Apparently, mother had a conversation with Mary, which was similar to Mary’s new perception discussed above. It seems like mother is the source of Mary’s guilt. The previous point of view seems to be a typical reaction from parents who

do not understand AN. Mary was able to verbalize the meaning of the images. She was able to tell me that she did not feel understood by her parents, that the language of AN is foreign to them (represented by the hieroglyph; see Figure 7) and that she felt a lot of anger following her conversation with her mother.

An important milestone was achieved during this session. For the first time, Mary expressed her feelings of anger out loud, which were well contained in therapy. However, these feelings and her understanding of her disorder need to be addressed with her family. Instead of holding in the anger it would have been good for Mary to also express her feelings out loud at home. This would help validate what she was experiencing inside the family dynamic.

Another important aspect was achieved during this phase of the treatment. From the transition between resistance to exploring the problematic, we can recognize the emergence of subjectivity in the art making. It seems like Mary is beginning to take ownership of her thoughts, emotions and feelings. It also seems like she is validating them by acknowledging them. During this phase of the treatment, we see that the otherness of the picture becomes hers. The art becomes a representation of her self. For instance, she represented the most important things in HER life in one drawing. The valentine represents HER family and SHE is the smallest heart. And finally, SHE is angry and the hieroglyph symbolizes the source of HER anger. Mary seems to be on her way to achieving the goals of therapy.

3.3.4. The Termination

With six sessions left till the end of the therapy treatment, Mary seemed to be concerned about future treatment. More importantly, Mary was able to address these issues directly with me. She wondered if she was going to have to continue with another therapist. She was able to say she did not want to continue and that this should be her decision. However, she also understood that my opinion would probably have an impact on future treatment. She said she did not want her mother to force it upon her, and if her doctor recommended further therapy she was afraid this might be the result. I told Mary that I agreed with her opinion and that I would make it a point for us (art therapist, doctor and parents) to respect her decision, however with her health in mind our recommendations could not change because of her opinion on the matter.

Once these concerns were put at ease, we were able to discuss her fears towards further treatment. Mary expressed that she wanted to do it on her own and that she needed a break from it all. She seemed a little angry when she expressed these thoughts, which was an improvement. She also said that starting all over again with a new therapist would be scary and overwhelming. We also talked about her thoughts on her therapeutic experience. Mary chose 5 words to describe her art therapy sessions. She said the sessions were *productive*, because many positive things came out from our discussions and that they were also *helpful*, yet *demanding* to assist every week. In order to help fix the problem she needed to *research* inside herself to find answers. It was also *confusing* for her since she often went home confused from what we had talked about. Mary was also curious as of why her questions were often left unanswered. This opened

the conversation on how my answers may not be respecting her needs and perhaps if she looked deep inside herself, she may find that she possessed the answers all along.

Mary also worked on a self-box during two of these sessions. Since we had discussed searching inside for answers, it only seemed appropriate to suggest this activity. The instructions were simply to do a self-portrait using a box. With the art materials provided, it was suggested that Mary place on the inside of the box what was the most private. The outside of the box should represent what is shown openly to the world. Mary seemed to like the idea of this exercise. She chose a medium size box and painted the exterior first and then the inside of the cover of the box. During the art making, Mary seemed to be letting go of her inhibitions by using paint instead of a pencil or an eraser, which could indicate improvement towards the issues of control. By the end of the session, Mary had paint on her hands and seemed to enjoy this. However, the following session Mary decided not to finish her box. Instead she chose a bigger box and asked if she could just wrap the box and not work on the inside. It was told that the box was hers and she could do whatever she wanted. She then proceeded to wrap her box in red cellophane paper leaving no entrance for the inside. Interestingly, for Mary, red symbolizes intensity and anger. Perhaps what is not accessible on the inside is what makes her angry.

For our last three sessions, it was suggested we do a revision of all her artwork. She seemed open to this suggestion and asked if she could bring her day planner to therapy so we could look at it together. The art revision went fairly well and it seemed like Mary was able to recognize her progress in therapy. She also found new meanings and discoveries from looking at her art images again. While reviewing figure 4, she

noticed her mother was not represented in the drawing. Since she was not quite sure what that meant she looked concerned. We talked a little about these concerns and it was suggested that Mary write in her journal about it. When we reviewed the red cellophane self-box, she did not like it. She said it was too simple because no details were added. I took the opportunity and helped her see a different perspective. Considering the description of the exercise, Mary not only chose to leave the inside of the box untouched but she covered the box in cellophane so no one could open it. Mary agreed that perhaps she was a little resistant to working on the inside of the box because sometimes it is a hard thing to do. It seems like Mary is recognizing the depth of her problems and that she may need more help even though we are ending the art therapy.

When Mary brought in her day planner, which was a fun ending activity to help the transition, we talked about this boy she liked. Mary told me she had asked him out on a date. She said it was not an easy thing to do but the experience was gratifying. Mary chose affirmation instead of having someone do it for her. Mary seemed proud of herself, just as I was. As a last quick drawing, Mary drew a before and after picture of her experience in art therapy (see Figure 8). The first figure symbolizes the beginning of art therapy. The closed door on top of the figure represents her closed attitude and anger at the beginning of the treatment. The second figure also represents her, but near the end of art therapy. Like the open door drawn on top of the second figure, she is now open to different perspectives. As the doors were opening, Mary said she was more willing to share her thoughts, feelings and emotions and she became more comfortable with me as her therapist.

When reviewing the artwork, Mary's progress becomes more noticeable. For instance, a heart is present in each drawing of the five first sessions. In the first drawing the heart is broken, which can lead to the assumption that her mental state of being is broken, just as her family portrait. While in the fifth drawing we see the heart that begins to heal. Her three hearts valentine that represents each member of her family is whole again. Perhaps the family is slowly evolving and changing their ways. We also recognize the presence of a heart near the end of the treatment. Mary mentions a boy she likes, which could indicate that her mended heart is now ready to love outside the family. This could also suggest a healthy separation-individuation process from the family. It seems like Mary's emotional state of being emerges from love-confusion within her family dynamic to the possibility of love for a young man.

Finally, as promised, we discussed my recommendations. I told Mary it would be beneficial for her to continue in therapy (verbal therapy if she preferred). However, that I strongly recommended that this decision was hers and hers only after hearing everyone's opinion, including her parent's. Mary decided to engage in verbal therapy. She added that it was her decision and seemed happy and relieved.

3.4. Interpretation of Mary's Favorite Fairy Tale

In one of Mary's art therapy sessions, without knowing exactly where this question would lead, I asked Mary what was her favorite fairytale. Curiously, she answered "Peter Pan". The purpose of this question was simply to see if there would be any link between Mary's favorite fairytale and her own life story. Interestingly enough, Barrie's (2003)

story of a young orphan boy named Peter Pan seemed to have a lot in common with Mary's story.

Peter Pan is a magical orphan boy who lives in Neverland. One evening while looking for his shadow, he flies in the Darling family's nursery window and meets the Darling children. Peter Pan quickly convinces the curious children to fly away with him to Neverland. Neverland is a far away land where children never grow-up. Peter Pan lives in Neverland with the lost boys and would like a mother to care for him and the boys. Therefore, he convinces Wendy (the eldest of the Darling children) to become their make-believe mother. In Neverland, Peter Pan, the lost boys and the Darling children live exciting adventures where they can escape life's responsibilities.

As we have seen earlier in chapter one, the physiological consequences of AN hinders the maturational development of the female body. Therefore, it seems appropriate to hypothesize that Mary has a fear of growing-up and perhaps the anorectic behaviors confirm a refusal to grow-up, just like in Peter Pan.

Another interesting link is the search for a mother. In the course of Mary's therapeutic treatment, a conflict between mother and daughter seemed significant. For instance, in Mary's drawing of a bird's nest (see Figure 3), mama bird seems emotionally unavailable for her family. Her empty gaze seems to be overlooking her baby birds' needs. Again, in figure 4 the mother's presence is not consciously noticeable. It is the father who cares for the baby. Even though the mother is physically present at every doctor's appointment, Mary seems to be threatened by her. It seems like Mary's mother has the need to rationalize her daughter's disorder by disregarding Mary's psychological state of being. It seems like Mary's mother does not realize that she can be part of the

solution by being emotionally present for her daughter. It only seems natural that Mary would also crave a mother or craves her mother's emotional presence.

When Mary talks about her childish fear of having other siblings, one could relate the fear with Peter Pan's own maternal experience. Peter Pan says:

Long ago ... I thought like you that my mother would always keep the window open for me, so I stayed away for moons and moons and moons; but the window was barred, for mother had forgotten all about me, and there was another little boy sleeping in my bed. (Barrie, 2003, p.145)

Perhaps Mary had an unpleasant experience that made her believe someone else would take her place. And maybe Mary's character was developed in function of this fear of rejection, resulting in "good-girl" behavior.

It is also important to show the anorectic behavior resemblances in Peter Pan's story. As mentioned earlier, Neverland is the land where children never grow-up and this seems concordant to AN. Also Neverland is the land of make-believe. As the individual with AN, in Neverland the children rarely eat. They eat make-believe food. The children also need to take care of their body size and maintain it to be able to fit in their tree houses.

Usually it is done quite easily, as by your wearing too many garments or too few, but if you are bumpy in awkward places or the only available tree an odd shape, Peter does some things to you, and after that you fit. Once you fit, great care must be taken to go on fitting, and this, as Wendy was to discover to her delight, keeps a whole family in perfect condition. (Barrie, 2003, p.96)

In the story, Wendy is the perfect mother, she is brave, in charge, responsible and caring and Mary seems to have all of these qualities. In my opinion, the scariest comment in Peter Pan's story, which is an unfortunate similarity to AN is: "To die will be an awfully big adventure." Whether we like it or not, an individual who refuses to eat and to grow-up, somewhat refuses to live even if this is an unconscious manifestation.

The story of Peter Pan ends when Wendy is safely returned home and grows-up to be a real mother. When Peter comes by to visit Wendy's daughter, 'Something inside her was crying "Woman, woman, let go of me."' (Barrie, 2003, p.229) Again, the refusal to womanhood resonates and the child within wishes to stay young.

After reading the story of Peter Pan and analyzing the content, it is not surprising that Mary had an attraction (whether conscious or not) to this fairytale. One is left to wonder why a person likes one story better than the other. My curiosity for this question, lead to interesting results. Hypothetically, it seems like a person would prefer one story to the next because they relate to it. For a therapist to know this may help the therapeutic process.

3.5. Discussion

Anorexia nervosa is a very difficult and mysterious disorder. Many theories have been written and researched over the years, however the aetiology of the disorder is yet to become a definite answer. It seems like the causality cannot be generalized because of its complexity. Many layers can be discovered with a thorough analysis. Each individual living with AN have their own stories and they each experience the disorder differently. From this case study, many clues were found that helped the therapeutic treatment,

however no specific cause could be identified. For instance, the pressures of adolescence, the fact that the patient was an only child, the assumption of the patient's mother being emotionally unavailable, insecure attachment and the parent's relationship all seem to be connected to the causality of the disorder. Therefore, one cause cannot be generalized, but the combination of life experiences for this particular patient could help explain the origins of his or her disorder.

Because of the complexity of AN and its pressing physiological concerns, it seems important to find new and efficient ways to improve the treatment. This study explores different therapeutic tools to help discover unconscious manifestations. Art therapy is a fairly new therapeutic approach that helps individuals living with AN have a more concrete experience. The art making can be less threatening than verbal therapy for the patient because of its quality of "otherness". The patient talks about the image created at first, then gradually links his or her story to the images and can finally make his or her own interpretations (as we have observed in Mary's case). This process seems to be ideal for this population. The person dealing with AN needs to unfold the secrets and mysteries delicately for the art therapy to be successful.

This paper explores AN and the personal unconscious in art therapy. From this research, it seems important to have tools to help guide the therapy. Art seems to be an excellent means for unconscious manifestations. Important tools such as the self-box, the bird's nest drawing, the family activity drawing, the favorite fairytale etc... all seem efficient tools that with interpretation, the therapist can find clues to help guide the therapy. I have learnt that it is important to rely on these clues because a patient with AN is easily distracted from what needs to be explored. It is also important to try new things.

For instance, asking the patient for his or her favorite fairytale proved to be an excellent revealing tool. Further research in this area would be beneficial to the counselling profession. It is unfortunate that the termination was forced upon because of the ending of my practicum. Mary most likely would have benefited from long-term therapy. However, I am fortunate to have had this great learning experience. I strongly believe that therapists working with children need constant contact with their worlds. For instance, I recommend viewing their movies and playing their games. These are priceless tools when needed.

References

- Aach-Feldman, S., & Kunkle-Miller, C. (1987). A developmental approach to art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 251-274). Levittown, PA: Brunner/Mazel.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC: American Psychiatric Association.
- Andreasen, N. C., & Black, D. W. (2001). *Introductory textbook of psychiatry (3rd ed.)*. Washington, DC: American Psychiatric Publishing, Inc.
- Barrie, J. M. (2003). *Peter Pan: Charming classics*. New York: Harper Festival.
(Original work published 1911)
- Bettelheim, B. (1989). *The uses of enchantment: The meaning and importance of fairy tales*. London: Penguin Books.
- Bodwin, R. F., & Bruck, M. (1960). The adaptation and validation of the Draw-A-Person test as a measure of self concept. *Journal of Clinical Psychology*, 16, 427-429.
- Bruch, H. (1962). Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine*, 24, 187-194.
- Bruch, H. (1973). *Eating disorders: Obesity, anorexia and the person within*. New York: Basic Books.
- Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. Cambridge (MA): Harvard University Press.
- Brun, B. (1993). The use of fairy tales in psychotherapy. In *Symbols of the soul: Therapy and guidance through fairy tales* (pp. 17-46). London and Philadelphia: Jessica Kingsley Publishers.

- Bunnell, D. W., Shenker, I. R., Nussbaum, M. P., Jacobson, M. S., Cooper, P., & Phil, D. (1990). Subclinical versus formal eating disorders: Differentiating psychological features. *International Journal of Eating Disorders*, 9, 357-362.
- Case, C., & Dalley, T. (1992). *The handbook of art therapy*. London and New York: Routledge.
- Chafe, C. (1995). *Art therapy with females having anorexia nervosa: Etiological and treatment considerations*. Unpublished master's thesis, Concordia University, Montreal, Quebec, Canada.
- Chafe, C. (1996). *A quantitative and qualitative analysis of a female anorectic patient's description of an art therapy experience: A combined approach to art therapy research*. Unpublished master's thesis, Concordia University, Montreal, Quebec, Canada.
- Crowl, M. (1980). Art therapy with patients suffering from anorexia nervosa. *The Arts in Psychotherapy*, 7(2), 141-151.
- de Groot, J., & Rodin, G. (1998). Coming alive: The psychotherapeutic treatment of patients with eating disorders. *Canadian Journal of Psychiatry*, 43, 359-366.
- Edwards, M. (1987). Jungian analytic art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 92-113). Levittown, PA: Brunner/Mazel.
- Ehrenzweig, A. (1967). *The hidden order of art*. London: Paladin.
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.
- Feder, B. & Feder, E. (1998). *The art and science of evaluation in the arts therapies: How do you know what's working?* Springfield, Illinois: Charles C Thomas Publisher, Ltd.

- Feist, J., & Feist, G. J. (1998). *Theories of personality* (4th ed.). Boston: McGraw Hill.
- Gordon, R. A. (1990). *Anorexia and bulimia: Anatomy of a social epidemic*. Cambridge, Massachusetts: Blackwell.
- Hammer, E. F. (1968). Projective drawings. In A. I. Rabin (Ed.). *Projective techniques in personality assessment* (pp. 366-393). New-York: Springer.
- Harnden, B. (1995). *Starving for expression inside the secret theatre : an art and drama therapy group with individuals suffering from eating disorders*. Unpublished master's thesis, Concordia University, Montreal, Quebec, Canada.
- Holbeck, B. (1987). *Interpretation of fairy tales. Danish folklore in a European perspective*. Helsinki: Suomalainen Tiedeakatemia Academia Scientiarum Fennica.
- Hubback, J. (1969). The symbolic attitude in psychotherapy. *Journal of Analytical Psychology, 14* (1), 36-47.
- Jolles, I. (1964). *A catalogue for the qualitative interpretation of the H-T-P*. (Rev. ed.). Beverly Hills, California: Western Psychological Services.
- Kaiser, D. H. (1996). Indications of attachment security in a drawing task. *The Arts and Psychotherapy, 23*, 333-340.
- Kaplan, A. S. (2002). Psychological treatments for anorexia nervosa: A review of published studies and promising new directions. *Canadian Journal of Psychiatry, 47* (3), 235-242.
- Krantz, M. J., & Mehler, P. S. (2004). Resting tachycardia, a warning sign in anorexia nervosa: Case report. *BMC Cardiovascular Disorders, 4* (10), 1-3.

- Leichner, P., Arnett, J., Rallo, J. S., Srilcomesuaran, S., & Vulcano, B. (1986). An epidemiological study of maladaptive eating attitudes in a Canadian school-aged population. *International Journal of Eating Disorders*, 5, 969-982.
- Levens, M. (1987). Art therapy with eating disordered patients. *Inscape, Summer edition*.
- McNiff, S. (1992). *Art as medicine: Creating a therapy of the imagination*. Boston and London: Shambhala.
- Milner, M. (1955). The role of illusion in symbol formation. In M. Klein (Ed.), *New directions in psychoanalysis* (pp. 82-109). London: Tavistock.
- Misra, M., Aggarwal, A., Miller, K. K., Almazan, C. Worley, M., Soyka, L. A., Herzog, D. B., & Klibanski, A. (2004). Effects of anorexia nervosa on clinical, hematologic, biochemical, and bone density parameters in community-dwelling adolescent girls. *Pediatrics*, 114, 1574-1583.
- Murphy, J. (1984). The use of art therapy in the treatment of anorexia nervosa. In T. Dalley (Ed.), *Art as therapy* (pp 96-109). New York: Tavistock Publications.
- Phelps, L., Augustyniak, K., Nelson, L. D., & Nathanson, D. S. (1997). Adolescent eating disorders, chronic dieting, and body dissatisfaction. In G.G. Bear, K. M. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 909-915). Bethesda, Maryland: National Association of School Psychologists.
- Phelps, L., Andrea, R. K., & Rizzo, R. G. (1994). Weight control techniques among female adolescents: A comparative study. *Journal of School Psychology*, 32, 283-292.

- Rubin, J. A. (1978). *Child art therapy: Understanding and helping children grow through art*. New York: Van Nostrand Reinhold.
- Rubin, J. A. (1987). *Approaches to art therapy: Theory and techniques*. Levittown, PA: Brunner/Mazel.
- Runberg, M. (1993). Fairy tales in the care and treatment of emotionally deprived children. In *Symbols of the soul: Therapy and guidance through fairy tales* pp.47-61). London and Philadelphia: Jessica Kingsley Publishers.
- Samuels, A. (1985). *Jung and the post Jungians*. London: Routledge and Reagan Paul.
- Schaverien, J. (1989). Transference and the picture. *Inscape, Spring*, 14-17.
- Seindenfeld, M. E., Sosin, E., & Rickert, V. I. (2004). Nutrition and eating disorders in adolescents. *The Mount Sinai Journal of Medicine*, 71 (3), 155-161.
- Smith, B. L. (1990). Potential space and the Rorschach: An application of object relations theory. *Journal of Personality Assessment*, 55, 756-767.
- Stice, E. (1994). Review of the evidence for a sociocultural model of bulimia nervosa and an exploration of the mechanisms of action. *Clinical Psychology Review*, 14, 633-661.
- Thelan, M. H., Powell, A. L., Lawrence, C., & Kuhnert, M. E. (1992). Eating and body image concern among children. *Journal of Clinical Child Psychology*, 21, 41-46.
- von Franz, M. L. (1996). *The interpretation of fairy tales* (Rev. ed.). Boston and London: Shambhala.
- von Franz, M. L. (1997). *Archetypal dimensions of the psyche*. Boston and London: Shambhala.
- Wallace, E. (1987). Healing through the visual arts: A Jungian approach. In J. A. Rubin

(Ed.), *Approaches to art therapy: Theory and technique* (pp. 114-133).

Levittown, PA: Brunnel/Mazel.

Weiner, I. B. (1998). *Principles of psychotherapy* (Second edition). New York: John Wiley & Sons, Inc.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock Publications.

Woodman, M. (1980). *The owl was a baker's daughter: Obesity, anorexia nervosa, and the repressed feminine: A psychological study*. Toronto, Canada: Inner City Books.

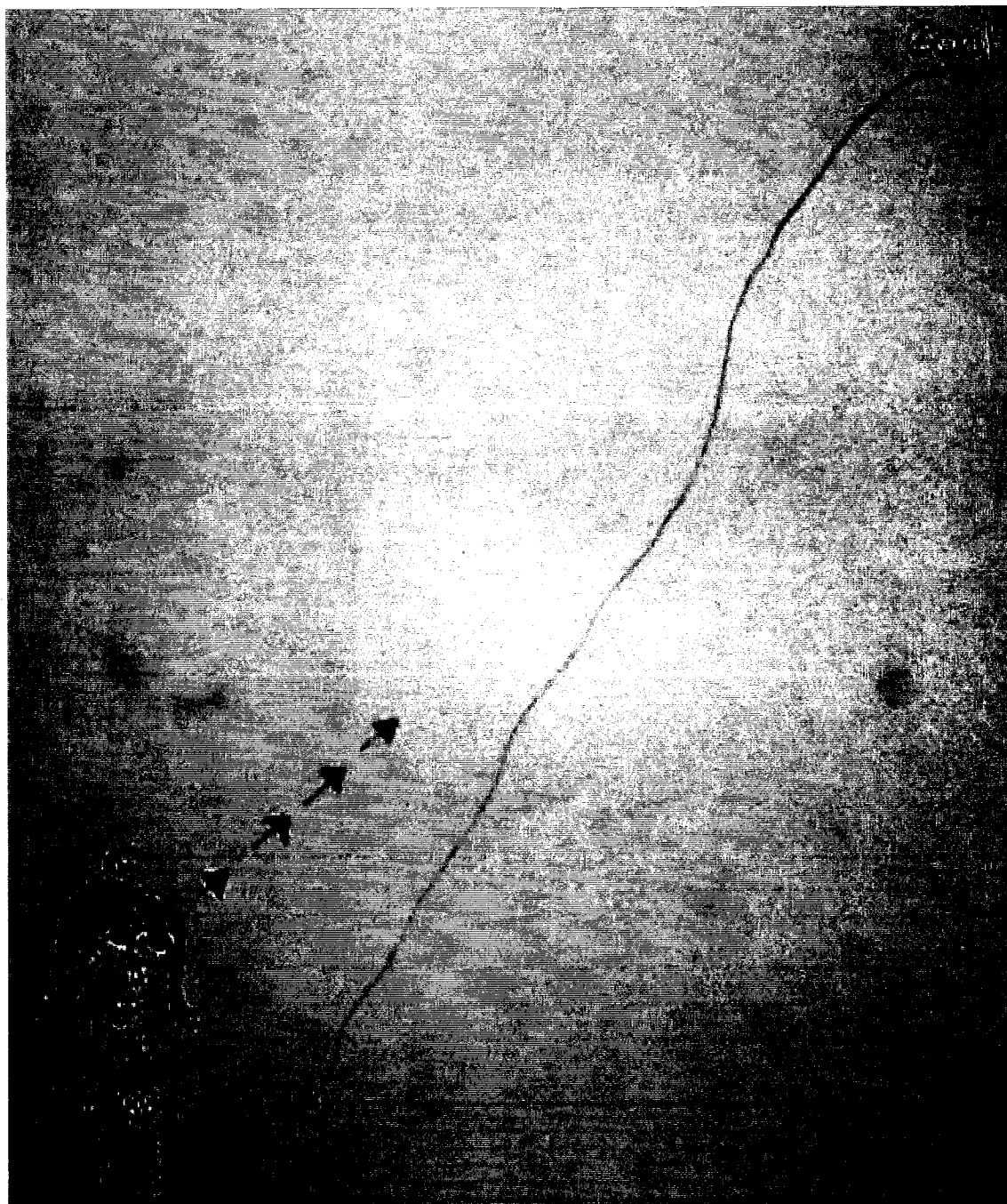


Figure 1

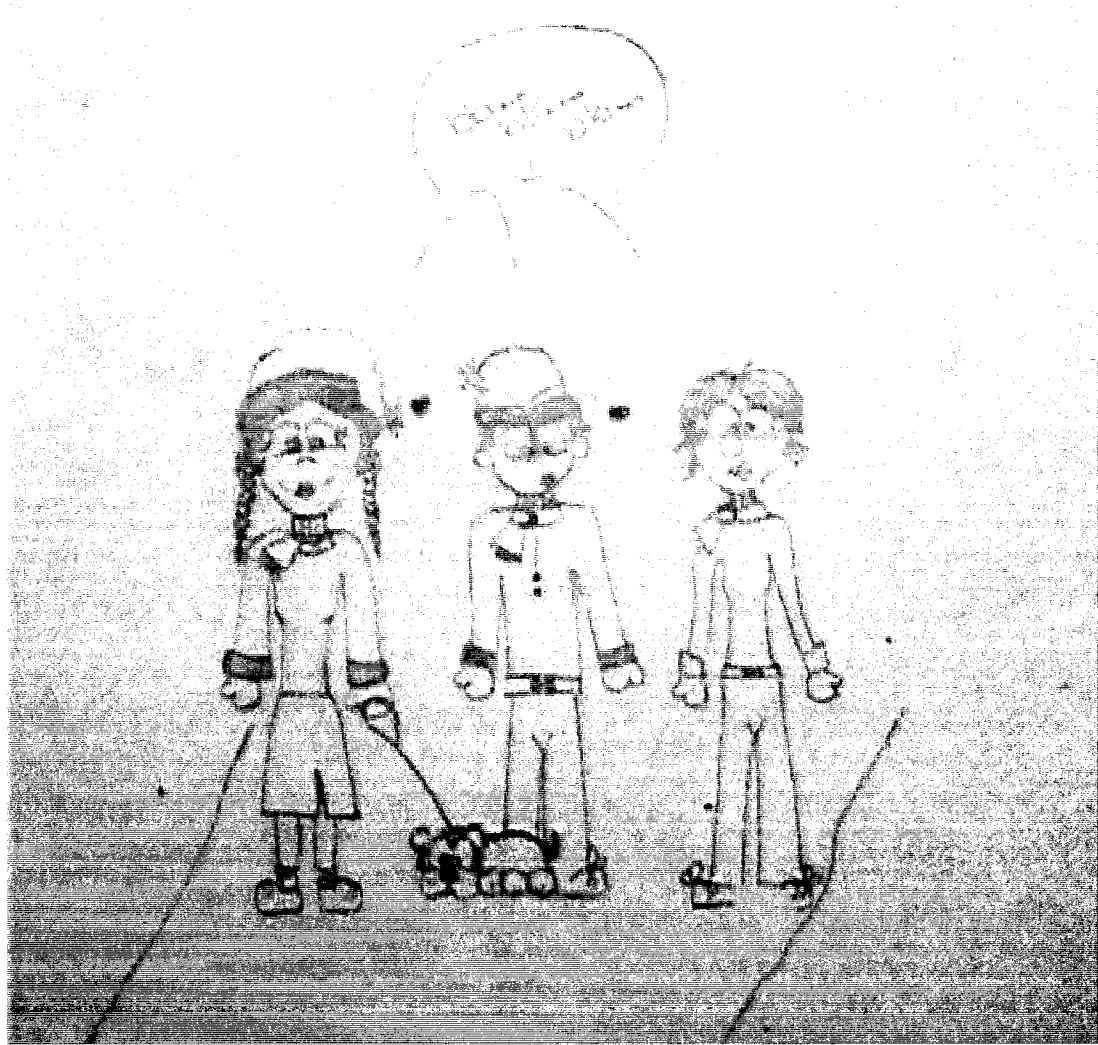


Figure 2

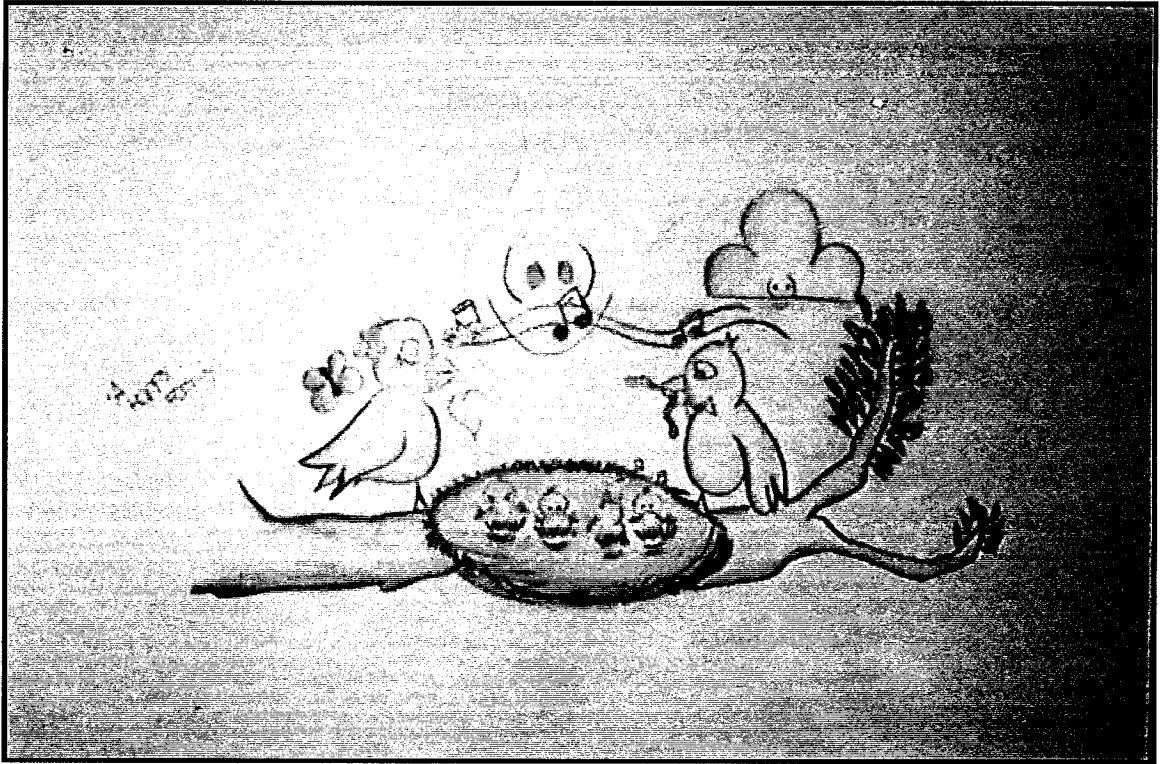


Figure 3

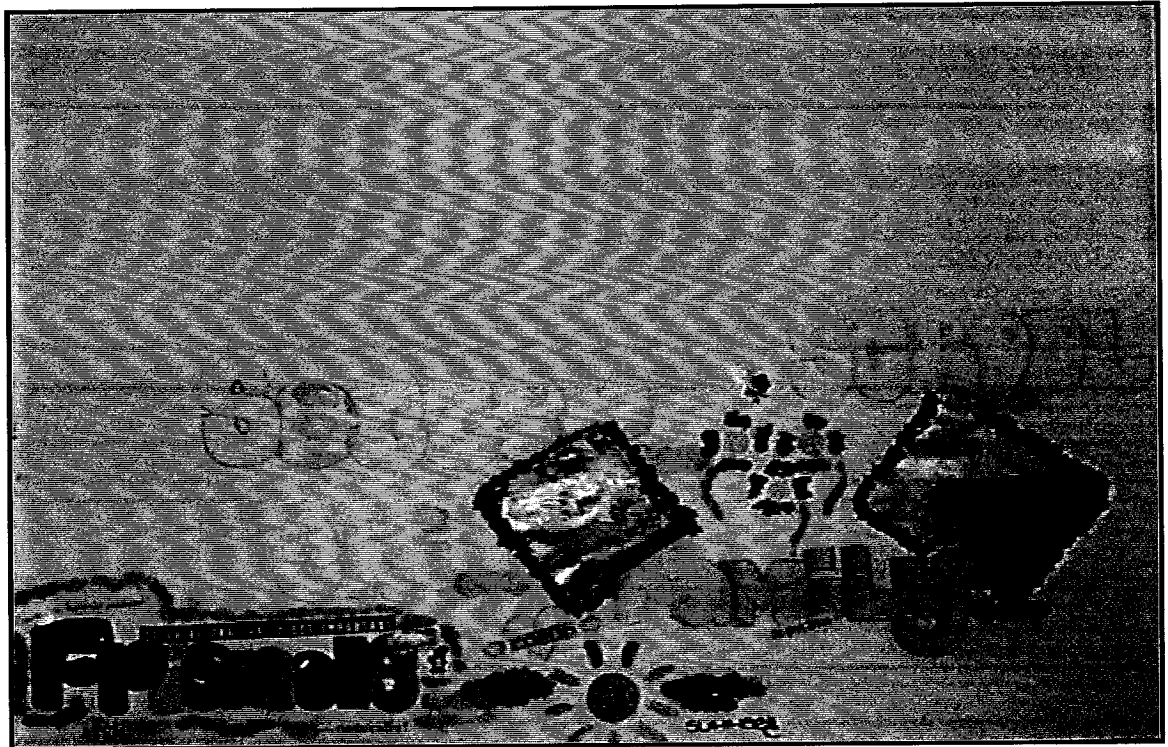


Figure 4



Figure 5

I hope this day will be a day
filled with lots of happiness. May
all my problems and concerns
vanish for just this one special day
hope that this day will help me
keep faith and hope throughout my
other difficult days...

Figure 6

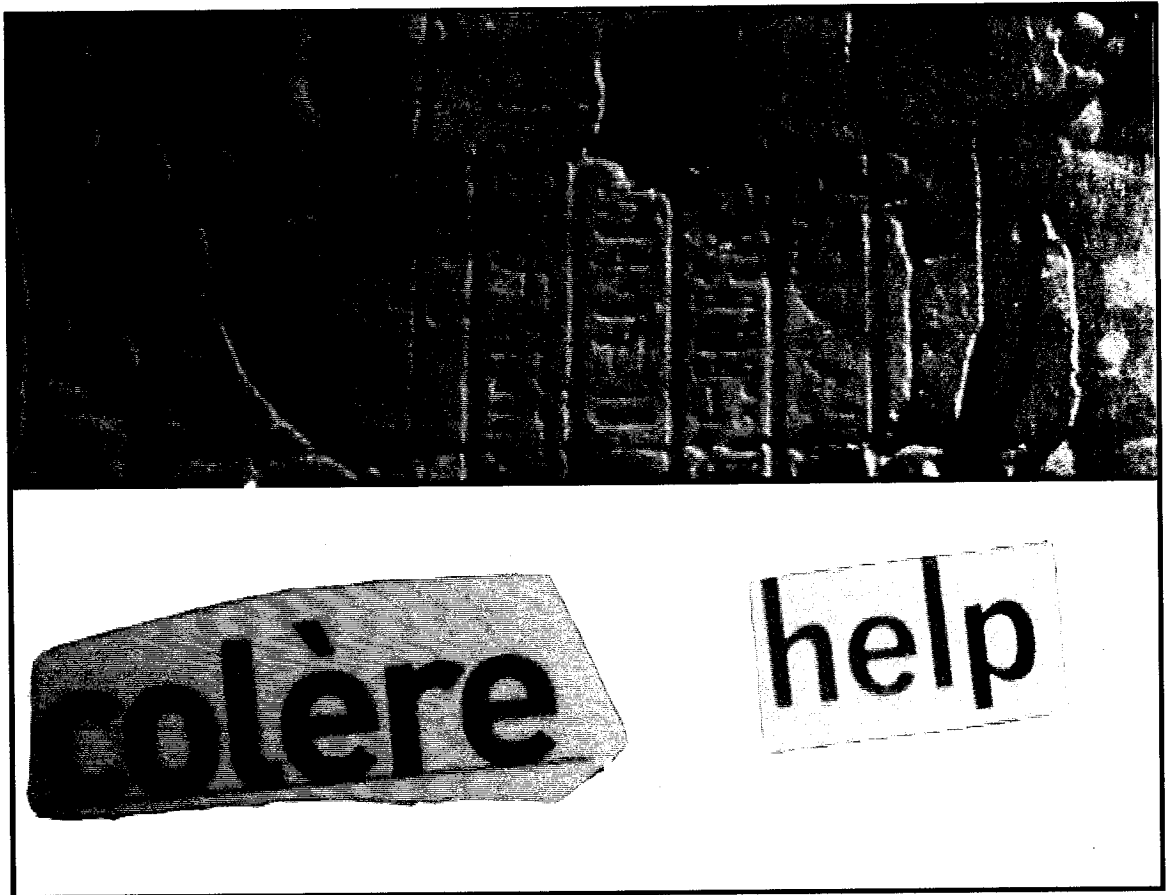


Figure 7

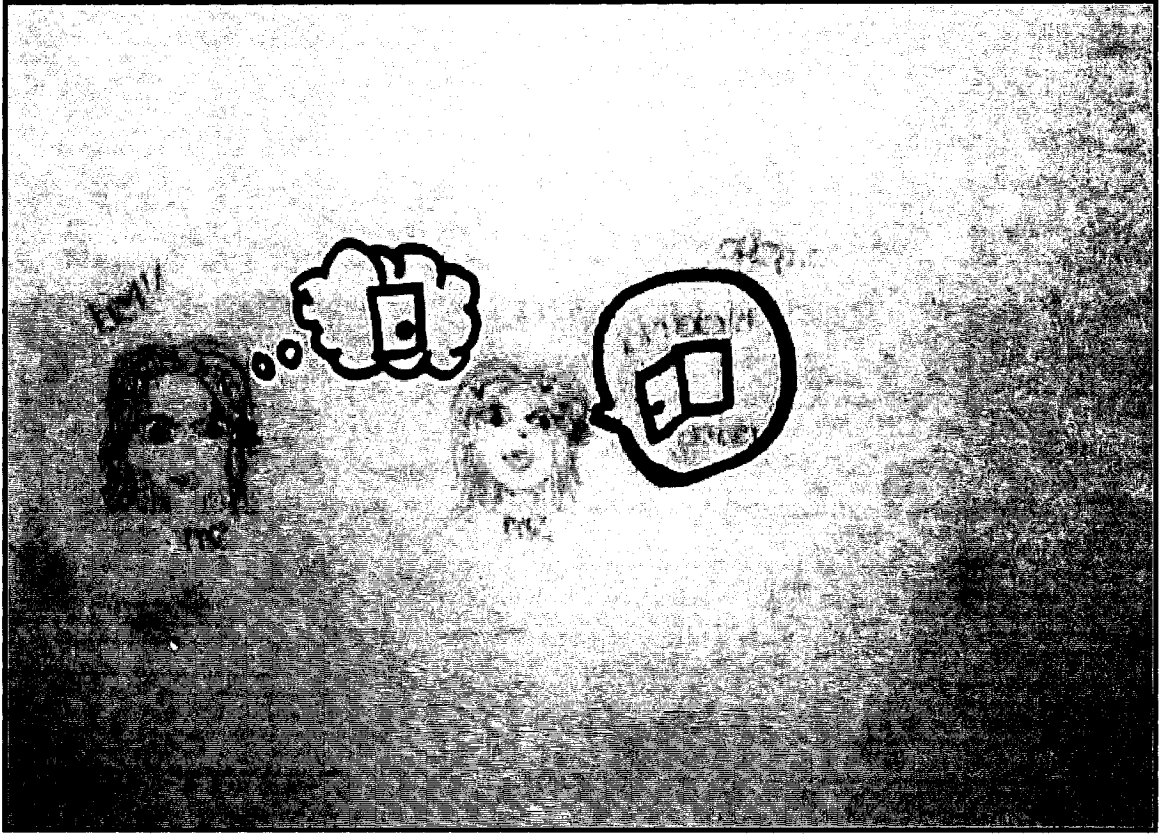


Figure 8

CONSENT INFORMATION

Art therapy student: Véronique Brun
 Concordia University
 1455 de Maisonneuve Blvd. West
 Montréal, Québec H3G 1M8

Practicum Supervisors: Irene Gericke
 Department of Art Therapy
 Concordia University

Sally Cooke
 Art Therapist
 Practicum site

Background Information:

One of the ways art therapy students learn how to be art therapists is to write a research paper that includes case material and work by clients they have worked with during their practicum. The purpose of doing this is to help them, as well as other students and art therapists who read the research paper, to increase their knowledge and skills in giving art therapy services to a variety of persons with different kinds of problems. The long-term goal is to increase the efficiency of the art therapy services.

Permission:

As a student completing a Master's degree in the Creative Arts Therapies Program at Concordia University, I am asking for your permission to photograph your artwork and include selected images in my research paper, along with a description of how you are using art in therapy. I am also asking for your permission to consult your medical chart for a period of one year (until I have completed my research paper). A copy of the research paper will be bound and kept in the Concordia University Library, and another will be kept in the Program's Resource Center. This paper may also be presented for educational purposes or published in the future.

Confidentiality:

Because this information is of a personal nature, it is understood that confidentiality and anonymity will be maintained and respected at all times. Neither your name, the name of the establishment where the art therapy took place, nor any other information that could lead to your identification will be used in the research paper. All session notes and artwork will be kept in a secure place.

Advantages and disadvantages regarding your consent:

To my knowledge, this consent should not affect in any way the course of your treatment in art therapy, whether you agree or not to participate in my research paper. This participation is voluntary, therefore you have the choice to discontinue the research and/or the treatment altogether without any justifications or repercussions.

Consent Form

I, _____, authorize Véronique Brun to:

- 1)
 - a) Reproduce artwork
 - b) Make video and tape recordings of sessions
 - c) Use case material

- 2) Use this material and information from my medical chart for educational and research/publication purposes.

I understand that no reference will be made to my identity and that at all times confidentiality will be respected.

I may withdraw my consent at anytime without my treatment being affected.

Signature of Patient: _____

Signature of Parent or Guardian: _____

(Only necessary if patient is under 14 years of age)

Date: _____