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Identifying conflicts of anorexia nervosa as manifested in the art therapy process

Dafna Rehavia-Hanauer, M.A.C.T. ATR¹

Psychosomatic Department, Sheba Medical Center, Tel-Hashomer, Israel

While working as an art therapist treating anorectic patients in an in-patient Eating Disorder Department at a major medical center in Israel, I became aware of a wide range of issues that arose within my art therapy sessions. Although, the eating disorder of anorexia nervosa has been explored extensively and a variety of psychological explanations have been proposed, the perspective taken by these theories did not seem to address directly the art therapy process for the patients with whom I was involved. As we know, anorexia nervosa is a multifaceted disorder. Over the years of my work as an art therapist, I realized that there was a need to provide a fuller understanding of the phenomenon of anorexia nervosa and the way it manifests itself through art work and from an art therapy perspective. I wanted to follow the central themes that arose in art and the art therapy process while working with anorectic patients. As proposed by Schaverien (1994), art and art therapy may symbolically replace food in the negotiation of the underlying causes of anorexia nervosa. As I followed the themes that emerged in the art therapy process I was involved with, I found that my patients were trapped in a pattern of conflicting themes. I therefore chose to focus on these conflicts directly. In this paper, I will concentrate on the conflicts that were identified in the artistic process and art products of 10 anorectic patients treated over a period of 6 months. The definition of the conflicts and the ways they appear in the art therapy sessions may be a useful tool for assessment and treatment of patients with anorexia nervosa. This study may also provide a more com-

prehensive description of the eating disorder anorexia nervosa that is directly tied to the art therapy process and as such may provide a new perspective on this disorder.

Literature review

In extensive previous research, several different factors have been defined that are important for understanding the eating disorder anorexia nervosa. These factors include socio-cultural, psychological, family, biological, physiological, and developmental factors. Yates (1989) stated that anorexia nervosa would necessarily involve interactions between socio-cultural, psychological, and biological forces and that these forces must then be integrated within a developmental framework. On a very basic level, anorexia nervosa can be defined as a psychosomatic illness that combines aspects of the physical body and the mind (Yates, 1989). Research into the biological and physiological factors involved in anorexia has focused on both the outcomes and causes of anorexia. Physical symptoms and signs usually reflect the effect of caloric restriction and subsequent weight loss (Pomeroy, 1997). Menstrual irregularities and decreases in neuro-hormonal discharge are common among anorectic patients (Yates, 1989). Because a majority of patients diagnosed with anorexia are females as were the participants in the present study, this paper will refer specifically to females with anorexia.

Cognitive approaches to anorexia nervosa view this illness in relation to a series of cognitive perception distortions about body weight, shape, and eating. The most documented of these distortions relates to concepts of body image. In a significant study, Slade

E-mail address: dafnarh@excite.com
(D. Rehavia-Hanauer).

¹ Present address: Pittsburgh, Pennsylvania, USA.

and Russell (1973) found that patients with anorexia nervosa overestimated their physical size.

Socio-cultural studies of anorexia nervosa focus on the role of society in the development of this mental illness. Bliss and Branch (1960) and Bruch (1973) proposed that media and social messages prevalent in western societies have propagated a vision of beauty related to thinness that is a central factor in the onset of anorexia.

Research that relates to family theory and dynamics has proposed that the internal structure of the family unit and especially the relationships between the family members are a central cause in the occurrence of anorexia nervosa. Eisler (1995) states that anorexia may appear within an over close, over involved family that has high expectations of its children and which is unable to provide the impetus and support for individuation and separation during adolescence. In relation to the internal structure of families, Minuchin, Rosman, and Baker (1978) proposed that the anorectic patient reflects a structure of internal conflicts that appears within the family.

Psychological research has proposed several different explanations for the onset of anorexia. An early psychoanalytical approach proposed that anorexia is based on a symbolic desire to be impregnated. This wish is unconscious and the denial of eating is basically a denial of the desire for sexual relations (Waller, Kaufman, & Deutsch, 1940). The issue of sexuality raised by this approach has been considered important by several researchers. As reported by Dare and Crowther (1995), anorexia has been related to cases of early sexual abuse and trauma and to the onset of sexuality in puberty. This approach sees the sudden entry into the world of sexuality as a traumatic and fearful experience that the anorectic patient has done everything to avoid. A similar approach to anorexia nervosa sees the Oedipus complex at the core of the illness. Anorexia nervosa appears as a result of the child's inability to handle the Oedipus complex in early childhood and on entry into puberty (Elizur, Tyano, Munitz, & Neumann, 1991; Schaverien, 1995a, 1995b; Waller, 1993).

Developmental approaches to anorexia nervosa pose that the processes of separation-individuation and personality formation are central factors in the onset of anorexia nervosa. Crisp (1980) points out that anorectic patients have an intense fear of entering adult femininity. This fear is related to both the physical and emotional aspects of growing up and becoming an adult. Bruch (1973) poses a related but different developmental issue. According to Bruch (1973), one of the main characteristics of anorexia is an ingrained sense of personal ineffectiveness. This personal sense of lack

of mastery and control results from a lack of individuation between mother and child in early infancy which is accentuated at the onset of adolescence because of the social message of increasing autonomy and independence. Ultimately, the child achieves a sense of control and mastery by placing extreme restrictions on the food intake of her body.

Selvini Palazzoli (1974) develops Bruch's theory by proposing an object-relations theory of anorexia. In Selvini Palazzoli's formulation the anorectic patient identifies her body with the bad internalized mother that has not been integrated in her psyche. The body is identified as a maternal object. Once physical changes start at puberty, the anorectic patient understands these changes as a direct attack by the internalized mother and an attempt to completely devour her. The anorectic response is to fight back against the internalized mother by strictly controlling her body through excessive dieting and exercise.

Art therapy has specific qualities that make it very suitable for treatment and discussion of anorexia nervosa. It does not depend on verbal interaction in order for therapy to take place and thus allows the patient to express unconscious and unintegrated internal materials without immediately activating defense mechanisms against this content (Rubin, 1987; Schaverien, 1996). The non-verbal nature of art therapy goes beyond the oppositional and defense mechanisms. In many cases the anorexia nervosa patient is resistant to therapy of any type. The presence within the therapy sessions of an artistic process that leads to a creation of an artistic product gives the patient's internal content a concrete form to relate to, just as with the use of food. Schaverien proposes that pictures may mediate between the inner and outer world, just as food may be understood as negotiating and mediating between the inner and outer world of the patient (Schaverien, 1994). The artistic artifact embodies all the conflicts, emotions and associations found in the anorexia nervosa patient's relationship with food and eating behavior.

Luzzatto (1994) in her analysis of pictures produced by anorexia nervosa patients pointed out that these pictures reveal a conflictual situation, termed by Luzzatto a "Double trap." This conflictual situation consists of paradoxical communication—"I need you—but you must not help me." Linesch (1988) suggested that anorexia nervosa represents an attempt to solve a psychological conflict with a physical resolution. This current study builds upon these conceptual and therapeutic positions by analyzing how anorexia nervosa is represented in the art therapy process and artistic creation. In this research I closely scrutinize the art therapy process with 10 anorectic patients and thus may offer a unique opportunity for describing this illness.

As will be described in the methods section below, the central analysis conducted in the present study related to the analysis of conflicts that emerge within the art therapy process. Accordingly, one of the major aspects of this study was the use of conflicts as a central organizing concept. As described in the literature, conflicts are an interaction between forces that aim to reach opposing outcomes. *Blos (1962)* has pointed out the important role of the conflict as a positive aspect of the maturation process. The main task of the adolescent is the development of the ability to resolve intra- and interpersonal conflicts. According to *Blos (1962)* this is the essential requirement for developing into a mature individual. The basic definition of a conflict (for both interpersonal and intrapersonal relations) is an interaction between incompatible desires, goals, and actions (*Blos, 1962; Cupach & Canary, 1997; Folger, Poole, & Stutman, 1997*). In intrapersonal conflicts, these forces, desires, goals, needs, and wishes are different aspects of the self. For example, Freud's structural concept of the self proposes different internal agencies that vie for power over the individual's thoughts, feelings and actions. These different agencies may be in conflict with one another, each pulling in a different direction. In a drive and defense model the superego defends the ego against drives and urges of the id. Essentially, this is a description of an intrapersonal conflict between forces that wish to achieve very different outcomes. Previous research has used the concept of conflict to describe the illness anorexia nervosa. *Stern (1991)* describes anorexia nervosa as the result of contradictory interpersonal currents. *Stern (1991)* states:

They [*anorectic patients*] are frozen developmentally, caught between opposing motivational currents. Typically, the opposition is between legitimate needs of the self (such as needs for emotional nourishment, affect containment, emphatic mirroring, or support for separation-individuation) and some form of characterological self-denial, self-sacrifice, or self-distortion that has its roots in early (and often continuing) requirements imposed by the family system—especially the mother-child dyad. Thus at one level (usually unconscious) the eating-disordered patient is seeking a missed developmental experience that is necessary for the growth of the self, while at another (often more conscious) level there is an apparent disavowal or repudiation of these need, and of the kind of object (or self-object) relationship necessary to meet them. (p. 87)

In this description of anorexia, Stern integrates developmental, social, personality, and psychodynamic approaches to anorexia within the context of opposing forces within the individual patient. This approach places early needs for emotional support and symbiotic relations that are still active within the anorectic

patient in opposition to the patient's current personal and social requirements for autonomy and individuation. These forces work to achieve very different outcomes and thus constitute a conflictual structure. Research into conflicts has shown that conflicts are present throughout an individual's development. *Dunn and Munn (1987)* and *Eisenberg (1992)* have documented interpersonal conflicts in early infancy and childhood between parents and infants. These conflicts are frequent and on going. As reported by *Lloyd (1987)* intra- and interpersonal conflict is a very common daily occurrence for adolescents.

The main advantage of using the concept of conflict in the description of anorexia in this study is that it allows the presentation of a complex picture of this illness. In this study the analysis of the data, revealed that anorectic patients expressed in various modes, the presence of opposing forces at work within her. The way these opposing forces functioned and were present within anorectic patients' self can be best described through the idea of conflict. This methodological use of the term conflict also has the advantage of allowing the description of anorexia to cross theoretical boundaries and propose options that integrate various theoretical approaches. Using conflict as the basic unit of description is a methodological decision and this arranges and directs the theoretical and empirical rich description of the data in the current study.

Research design

The overall perspective of this study is of an informed-insider investigating her own reports collected over a period of 4 years working as an art therapist with hospitalized anorectic patients in a psychosomatic ward in an Israeli medical institute. Recent advances in qualitative research methods have proposed that the world of human action can only be understood by looking at the participant's subjective understanding of that world (*Geertz, 1973; Maxwell, 1996; Packer, 1989; Ricoeur, 1991; Rosaldo, 1989*). This point of view of a participant art therapist, informed-insider's perspective allows a rich description of the components that interact within the art therapy session. *Shaverien* takes a similar position when she proposes that the art therapist should start research from the therapist's current professional, conceptual and physical position (*Schaverien, 1995a, 1995b*). This methodological approach which focuses on the investigation of the conflicts, the artistic processes and art products that emerged from art therapy sessions with patients who have been diagnosed as having anorexia nervosa, produces information that is deeply embedded within the art therapy process that I as an art therapist have been directly involved in.

The study is based on a close analysis of art therapy session summaries and is not committed a priori to any particular theory. The analysis investigated 4 years of weekly art therapy session reports collected during treatment of 10 anorectic patients by the participant art therapist. The patients that the reports relate to were all diagnosed as having anorexia nervosa using criteria from the *Diagnostic and Statistical Manual of Mental Disorders 4th Edition* (American Psychiatric Association, 1994), clinical interviews, and hospital observations. The diagnosis was conducted by the medical staff (dietitians, nurses), the ward psychiatrists and the psychological staff (psychotherapists and expressive therapists) of the hospital.

The session reports were all written and collected while these patients were in the hospital. The average hospitalization period was 5.9 months. These reports relate to anorectic patients within the age range of 15–17.5 years of age. These reports were not written originally with any intention of using them for research but rather they represent the participant researcher's session summaries following each art therapy meeting. These reports are extremely detailed and include illustrations of the original art works and products produced by the anorectic patients during treatment. All art therapy sessions took place in the same art room and related to weekly sessions of 50 minutes.

The data analysis employed a cyclical, grounded theory approach and was conducted in five stages of analysis. Each stage of the analysis had its own aim. During every stage of the study, each report was read carefully and notes were taken throughout the reading and analysis process so as to document the researcher's on-going thoughts and insights about the data. The product of the first stage of analysis was a series of notes on the identification of recurrent themes that characterized the reports of several patients. The second stage of analysis defined the nature of the recurrent themes that had been proposed in the first stage. This definition of themes involved looking for the scope of the theme, the manifestation of this theme in the art therapy process and the significance of the theme for the patient's treatment and development. During reconsideration of the data set, I realized that the proposed themes were not individual entities but rather components of a structure that involved binary opposition. These binary oppositions were termed conflicts. In all, 32 potential conflicts were defined.

The third stage of analysis evaluated the proposed list of conflicts for their usefulness as a tool for describing the content of the session summary reports of the 10 anorectic patients. In addition, the nature of the conflicts and their manifestation in the

art therapy process were reexamined. The conflicts were re-categorized into a smaller set of more inclusive categories. The list of 32 potential conflicts was reduced to 8 conflicts. In the fourth stage of analysis, the conflicts were defined in both operational and theoretical terms. The analysis focused on identifying the conflicts and defining the conflict indicators in both the artistic process and product in the art therapy meeting.

During the fifth stage, the proposed conflicts and the reliability of the conflict indicators were evaluated. Two additional independent readers were used to evaluate the reliability of the conflict definitions and indicators. The readers were two experienced and certified art therapists from a recognized institution of higher learning. Each therapist was given a packet that included the definition of the conflicts, a list of conflict indicators and 20% of the researcher's session summaries following each art therapy meeting. The 20% of the researcher's session summaries were chosen randomly from the complete data set. Each reader independently read and analyzed the session summaries. The readers were required to define and mark on the report the conflicts that they found in the summaries that they read. These independent analyses were compared to the researcher's analysis in the preparation of these materials and a measure of inter-rater reliability was calculated. In addition the readers were asked to provide expert opinion as to the definition of each of the conflicts. The result of this stage of analysis was a modification to the list of conflicts. Two of the conflicts were found to overlap with the other conflicts and therefore the list of conflicts was reduced to six core conflicts. The readers' comments were used to fine-tune both the definition of the conflicts and their list of indicators.

Results: the six conflicts of anorexia nervosa

Before we can address the definition of the conflicts, the first issue that has to be related is the inter-rater reliability of the conflicts and conflict indicators. As described in the research design, two readers (experienced art therapists) were given 20% of the session summaries to independently analyze for conflicts. Their analysis was compared to the researcher's original analysis of conflicts from stage four. The levels of inter-rater agreement with the readers were relatively high. The first reader's range of inter-rater agreement with the researcher was from 78.5 to 87.5% with an average score of 82%. The second reader's range of inter-rater agreement with the researcher was from 74 to 94% with an average score of 85%. These results suggest that the definition of the conflicts and their indicators is reliable.

Conflict one: Verbal and/or emotional-behavioral resistance to art therapy and attraction to artistic materials and the creative artistic process

As found in the analysis, this conflict is especially prevalent at the initial stages of treatment with anorectic patients. The anorectic patient verbally and physically expresses resistance to any participation in the art therapy process. This resistance reflects an internal emotional state that involves antagonism towards the creative process and the art therapist (or what she represents i.e., an authority) within the therapy session. On a verbal level this resistance and antagonism is communicated through expressions of hostility, suspicion, contempt, and objection to artistic materials, the art therapist and the creative process. Some examples of these objections are: “What, are we in kindergarten?” “What am I supposed to do here?” “What are you going to find out about me?” “I don’t want to draw and I don’t know how” (to draw, paint . . .). On a physical level, this resistance can be expressed by physically moving away from the therapist or by the patient turning her back to the therapist. Some patients express their resistance by physically communicating extreme exhaustion. In this state, anorectic patients may yawn, place their heads on the table, or even lay down in the corner. In one case, a patient actually hid in the corner with her back to the therapist and her head in the corner. At the same time this resistance is being communicated, they also communicate their desire and curiosity with art materials and the creative process. These conflicting communications may be simultaneous or appear with a time lag within the same therapy session. On a physical level, these patients are drawn to the artistic materials. They handle artistic materials that have been laid out before them. The anorectic patient seems unconscious of this desire and may suddenly find herself feeling the texture of paper or suddenly scribbling on paper. At the same time the patient may verbally express resistance to the art therapy process and to working with artistic materials in general. Verbally, they may begin to discuss their artistic tastes, technical artistic knowledge and may request very specific and sometimes unusual art materials.

To exemplify the presence of this conflict within the art therapy process consider the vignette:

Lee in her first session looked at me with a cold, hostile expression. After sitting down, she moved her body so as to be as far away from me as possible without getting up. She held her head at an angle with her chin slightly raised, and the general impression was of hostility mixed with contempt. Her posture communicated her suspicion of the whole situation. She chose a piece of paper from the table in front of her and began to draw with a

pencil. She held the pencil at a distance from her by slightly moving her body backwards. The pencil was held only by the top end. The way she positioned herself and held the pencil communicated her contempt of the artistic process. She acted as if she was following orders but without any desire to actually participate. Her drawing slowly produced an outline of a guitar in the center of the page. She became more involved in her drawing and the way she held her pencil changed. She moved her hand down the pencil and held it in a manner that allowed much greater control. She also began to use colored pencils. While she worked on the drawing, her expression changed and she seemed to be concentrating on the drawing itself. When she finished the drawing, she looked up from the picture. She returned to the posture and expression that characterized the beginning of the session. Her expression was cold, hostile and suspicious. However, she was curious to know what her picture tells me and what can I say about the picture that she doesn’t know.

Emergent conflict indicators

The following indicators of the first conflict emerged from the multiple repeated analyses of the reports. It should be noted that these indicators did not appear in isolation but rather came in collections of different indicators. It is also important to point out that this set of indicators is not to be taken as a classification system that can be used in isolation for diagnosis. These indicators need to be considered together and in their context.

Behavioral indicators of resistance to art therapy:

- (a) Avoidance behaviors.
- (b) Active resistance behavior.

Verbal indicators of resistance to art therapy:

- (a) Statements of hostility.
- (b) Statements of contempt.
- (c) Statements of suspicion.
- (d) Statements of passive resistance.
- (e) Statements of devaluation.

Behavioral indicators of attraction to art:

- (a) Touching and sensing behaviors.
- (b) Artistic activity behaviors.

Verbal indicators of attraction to art:

- (a) Statements of previous artistic experience.
- (b) Requests for artistic materials or knowledge.
- (c) Statements of pride in art work.

Conflict two: Intensive creation of an artistic object and the desire to destroy it

This conflict arises during the patient’s active participation in the creation of an artistic object or

immediately following completion of the artistic object. While creating the artistic object, the anorectic patient expresses feelings of disgust in relation to the artistic object, herself as a person, parts of her physical body and previous artistic objects that she has created. The patient may even express the desire to destroy the artistic object. These feelings of disgust come after the patient has actually done a significant amount of work on the artistic object and has put in effort to actually create the object. This effort may be half an hour of intensive work but in some cases was the result of several sessions of work. This period of intensive work by the anorectic patient produces an artistic object that is characterized by its emphasis on accuracy, controlled production and attempts to make the artistic object beautiful. These attempts to beautify the object include things such as making sure that the color used is equally spread and of same hue, choosing the most suitable color to fit the object, or the addition of various decorations to the object. Following this period of intensive work on the artistic object, the anorectic patient states her disgust with the object and desire to destroy it. These statements are combined with statements of personal devaluation such as “I am absolutely without talent” or “I am not good at anything.” In some cases, the patients act out their desire to destroy their artistic works by tearing up the paper they are working on and throwing it in the trash, cutting their work with a knife, complete erasure of the object that has been drawn, or squashing a clay artifact they are working on and returning it to its original form of a lump of clay.

To exemplify the second conflict consider the following vignette:

Lea's first 2 months of treatment were characterized by a consistent desire to destroy all of her works. An agreement was made between Lea and myself that she was not allowed to destroy her works but instead, I as her art therapist would keep them for her. At her tenth meeting she began to create a small vase out of clay. She kneaded the clay making it soft and pliable, and then she made a solid rounded cylindrical shape with her hands and then began to dig into the bottom of the clay and extract small pieces. The next session while continuing working on the clay vase, she made comments relating to her body. Specifically she stated that, she would not want her body to change and become round. At the beginning of the next session, she looked at the vase and said “it has a round boring shape; I need to add something to it. It is not enough to have a round vase.” While making these statements she felt the vase, slowly stroking the outlines of its shape. She then stated that “the vase is empty and boring, its needs to be fuller.” She continued by making a small flower bud for decorating her vase. She worked intensively on this decoration, making, modifying

and remaking this bud several times. In all, three clay flower buds were made and destroyed. Finally, she attached the final decoration to the outside of the vase. This took the whole of the session. In the next session, she stated that what was needed for the vase was a leaf. She chose a small piece of clay and began to form a leaf shape. Having completed a leaf shape she then stated, “It is too long” and quickly squashed it returning it once again to its original clay form. Once again using the same piece of clay she made another leaf, this time she stated, “It is too wide.” Once again she squashed the piece of clay and started over. She made another leaf and stated “it is too narrow” and once again she squashed the clay leaf. She then, once again using the same piece of clay made yet another clay leaf. This time she stated, “Its size is just not right for the vase.” Finally she gave me the vase and told me to keep it.

Emergent conflict indicators

The following indicators emerged in the process of the analysis of the second conflict:

Behavioral indicators of intensive creation:

- (a) Artistic accuracy behaviors.
- (b) Artistic decoration behaviors.
- (c) Emotional involvement behaviors.

Verbal indicators of intensive creation:

- (a) Statements of positive involvement.
- (b) Requests for artistic help.

Behavioral indicators of destruction:

- (a) Erasure behaviors.
- (b) Destructive behaviors.
- (c) Destructive behaviors in art.

Verbal indicators of destruction:

- (a) Statements of rejection of art.
- (b) Statements of destruction.

Conflict three: The desire and need to be looked after and held and the verbal inability to directly express this desire and need

In the current analysis, this conflict was mainly found to arise at the beginning of treatment. However, this conflict can arise at any stage of the treatment of an anorectic patient. The appearance of this conflict is connected to the state of the patient's illness. The more severe the symptoms of anorexia are, the greater the likelihood is that this conflict will appear. In this conflict, the anorectic patient communicates her need to be looked after and held. This request for help can be expressed through the patient's interaction with the artistic object or through the physical condition

and behaviors of the patient. Anorectic patients with severe symptoms are extremely thin. In this condition they are very weak and are consistently tired. Any physical or mental activity requires enormous effort from the patient. In some cases, these patients cannot rise from their beds. Although they are in a severe physical condition that obviously involves receiving help, they verbally make no direct requests for help from the therapist in any form. Through their physical condition and by avoiding any verbal request for help, they communicate their wish not to be and not to exist. Within the art therapy process, the request for help is expressed through the thematic content of the artistic object. For example, one patient drew a very thin female figure lying diagonally (in an impossible position) above a sharp sword pointed at her back. The figure faces death and will not be able to hold herself from falling on the sword. This creates a situation in which only external intervention could actually save the thin figure. A common theme that reflects this indirect call for help is the theme of drowning. A more direct representation of this need and desire for help is the use of motherly images. Drawings of babies in cribs or young birds in a nest can be used to express the desire and need for help. In some cases, the patient verbally relates to the thematic content of the artistic object. The patients desire to be held and receive help is expressed in relation to the constructed figures. In the patient's formulation, it is the figure and not the patient who desires to be held and needs help. For example, one patient working on a sculpture of a girl stated, "the girl's legs have to be strengthened so that she won't fall."

Although the physical condition and artistic representation communicate the patient's desire to be held and the need for help, the anorectic patient does not verbally express this need or desire directly. An extreme form of this conflict is the artistic expression of the desire for death. Death is portrayed as an encompassing experience that will bring the patient peace through physical holding. In some cases, the imagery of death that is used in this conflict is reminiscent of images of the womb. Artistic examples of this include drawings of figures in graves, figures completely covered by earth or figures laying among soft clouds and bleeding.

To exemplify the third conflict consider the following vignette:

At the twenty-second art therapy session I placed on the table a piece of (18" by 12") paper which had been folded into four sections in front of Micki. The paper was divided into four equal sections. Micki was in a very depressed state following a slight rise in her body weight. I suggested that we conduct a discussion in painting. The rules of the discussion

were that one person would start to work on a specific panel and then the other person would respond and vice versa. Micki expressed her willingness to cooperate in this discussion. I started by drawing a line at the top left section. The line was at the bottom of the panel and it had a curved center. The line invited participation through the filling in of the curved center. She responded by painting a black patch of color at the top of the panel. Micki started on the next panel below the panel we had worked on. Micki took a black oil pastel crayon and colored a third of the panel completely black. This section was horizontal and started from the line of the page. I responded by making a curved, curly line in pencil opposite the black section. She continued by making a jagged black patch that covered the top of the page. This patch obliterated the top section of the curved line I had made. I responded by making a gray patch at the bottom of the page. The gray patch was made using an oil pastel crayon and completely covered the bottom of the page. The gray patch ended with a sharp slope to the end of the page. Micki responded by making a black patch on top of the gray. Slowly the black patch turned into the form of a figure. The figure partially covered the gray area. The effect of this painting was of a figure lying on top and partially within the gray area. She then proceeded to draw straight lines from the jagged black area at the top of the page into the laying black figure at the bottom of the page. These lines were drawn with a pencil. The area between the black figure and the jagged black area was covered with these pencils lines. I responded by strengthening the gray area and adding gray to the lines drawn by Micki. The effect of these additions was to soften the lines Micki had drawn. I asked if she wanted to give a name to the panel. After hesitating, Micki named the panel "a woman in a grave."

Emergent conflict indicators

The following indicators emerged as descriptors of the third conflict:

Behavioral indicators of the desire and need for help and to be looked after:

- (a) Physical expressions of weakness.
- (b) Physical expressions of the need to be held.
- (c) Artistic expressions of the need for help and to be looked after.

Verbal indicators of the desire and need for help and to be looked after:

- (a) Indirect requests expressing need.
- (b) Projected requests for help on art object.

Verbal indicators of the inability to express the desire and need for help and to be looked after:

- (a) Statements of denial of illness.
- (b) Statements of self-devaluation.

Conflict four: The need to be dependent and in a relationship with others and the desire to be autonomous

This conflict arises after the initial stages of therapy have addressed the patient's resistance to treatment. This conflict arises while a relationship of trust is being built between the therapist and the anorectic patient. The anorectic patient may be suspicious of the therapist and may resist the physical closeness and intimacy of the individual therapy session. The anorectic patient distances herself emotionally and physically from the therapist. For example, a patient may express extreme anger and not be willing to come to therapy or the patient may test the endurance of the therapist in being with the patient. The conflict is between the patient's needs to be in a childlike relationship with others and her desire to be autonomous. The anorectic patient wants to be supported and helped by those around her, just like a small child with her parents. For example the anorectic patient can assume an embryonic posture in the therapy session. This type of relationship includes the need for constant reassurance and proof of unconditional love and acceptance. This relationship is symbiotic in nature. The patient may be unconscious of this need for a symbiotic relationship with others. At the same time, the anorectic patient desires to be autonomous. She desires to separate herself from her surroundings and to create her own individual and independent personality. She desires to make her own decisions and take control of her life. Her physical development enhances this conflict. Bodily changes, such as the physical developments of puberty, cause changes in the way her surroundings relate to her and how she relates to herself. With the appearance of physical indicators of womanhood, it becomes difficult to maintain the symbiotic relationships that the anorectic patient needs. In addition the anorectic patient becomes fearful that she will lose the love and acceptance of those around her. In this state the anorectic patient is extremely sensitive to any comments made by those around her. Every utterance is analyzed by the anorectic patient and categorized as proof of acceptance or rejection by the people around her.

To exemplify the fourth conflict consider the following vignette:

Gal chose to paint a boat in her seventh art therapy session. She chose a 9' by 12' piece of paper and drew a boat with colored pencils. The boat was small and situated on a calm blue sea. In a distance from the boat she drew a small island. She began to speak about the painting and said "My dream is to be alone on the boat and to reach a distant island and live in a small house on the island." She kept fantasizing of a life of her own. Then she continued

by presenting an opposing desire for a close loving family relationship "I want the boat to take me with the people I love, with my family for a holiday in a terrible place² . . . eh eh (self-correction) . . . a calm place." In her verbal expression, she mixed the Hebrew terms Ga Rua (meaning terrible) and Ra Gua (meaning calm). The terms of calm and terrible were directed at the presence of her family in close contact with her on the fantasized island.

Emergent conflict indicators

The following indicators emerged as descriptors of conflict four:

Behavioral indicators of the need to be dependent and in a relationship with others:

- (a) Childlike behaviors.

Expressions of dependence in the art process:

- (a) Images and symbols.
- (b) Use of art materials.

Verbal indicators of the need to be dependent and in a relationship with others:

- (a) Expressions of the desire for a relationship.
- (b) Expressions of fears of intimacy.

Behavioral indicators of the desire to be autonomous:

- (a) Distancing behaviors.
- (b) Aggressive behaviors.

Expressions of the desire for autonomy in art:

- (a) Images and symbols.
- (b) Composition.
- (c) Destructive acting in the art work.

Verbal indicators of the desire to be autonomous:

- (a) Expressions of aggression.
- (b) Expressions of self-distancing.

Conflict five: The physical development of female sexuality and identity and the rejection of these physical developments and identity

This conflict may arise at any stage in the art therapy treatment and is related to physical developments. For the anorectic patient this conflict arises with the appearance of the physical indicators of female sexuality such as the initial growth of breasts, the appearance of genital hair and the beginning of the patient's period. These physical changes include

² Please note that the Hebrew terms used by Gal in this sentence were Ga-rua that means terrible and Ra-gua that means calm.

changes in height, weight, and the shape of the body. The patient's body undergoes a series of relatively rapid physical changes that are associated with adult female sexuality. While the body's appearance changes rapidly, the patients' mental representation of the body does not. The anorectic patient rejects these changes imposed on her body and on top of that is fearful of these physical changes and developments. This may explain the patient's extreme discomfort with any type of physical contact or intimacy.

In art therapy, this rejection of the body may be expressed through the verbal denigration of female figures and the execution of direct changes to the figure. These changes can be the removal of body parts, the reduction of quantities of material from the female sexual indicators and the redrawing of external contours. The patient may be disgusted by the indicators of female sexuality that have changed her body. For instance a patient may state "I am a pig," "I am fat," or "I am a cow." Disgust with the patient's body can also be expressed through extreme cleaning rituals such as washing and rubbing her hands till the skin is red and sore. In art this can be expressed as the avoidance of art materials which consist of thick liquids or soft, flexible solids such as clay.

The anorectic patient's physical changes are accompanied by personal and social sexual urges, desires and the verbal and non-verbal communication of these desires. Just as with the physical changes, the anorectic patient rejects and attempts to deny the presence of these urges, desires and communications. The anorectic patient experiences these physical changes and internal developments as an assault on her body image and self-identity. She has a self-identity as a young girl without the explicit sexual overtones or responsibilities of adult female identity. Her immediate social surroundings, such as parents and peers, are sensitive to her physical changes and respond to her according to her physical appearance rather than her internal development of self. This creates a situation in which the anorectic patient has to contend with internal, physical, and social communications which she rejects and denies. She experiences these new situations as inconsistent with her own identity. These urges and desires cause a sense of fear and confusion in the anorectic patient and therefore they are denied and rejected. The anorectic patient expresses aggression against her own body. For example the anorectic patient may cut herself repeatedly or deny her body's basic requirements of food and rest. In art therapy, this aggression is expressed by the use of images expressing self-punishment such as tied female figures, hung female figures, burnt female figures and dead female figures.

To exemplify the fifth conflict consider the following vignette:

Danni looked through a magazine searching for ideas. She rejected any suggestions I made stating that she wanted to decide by herself. She began to draw on a 9" by 12" piece of white paper. She marked the borders of the page by drawing a pencil line around the whole page. She drew a picture of a boy in the middle of the page close to the bottom of the page. The boy is drawn from the back so that his face cannot be seen. One of his hands is raised. He is not wearing any top but is wearing trousers. She then prepared acrylic colors and painted the boy. Danni gave the boy a deep sun-tanned tone to his skin. Then she said "What is he, sun-tanned or dirty?" She then drew a path around the figure leading to the top of the page and added a red apple to the boys raised hand. She considered out loud how to paint his trousers with acrylic. She said "Shall I make his trousers dirty?" She painted his trousers leaf green. She painted his hair black and she was very pleased with her painting. She said that he reminded her of the Biblical character Adam. In her next session she began to draw a female figure at the other end of the path at the top of the page. She called this character "Eve." Eve had a very female body including the indicators of adult femininity. She painted Eve with very pale colors, and dressed her with a small green swimming suit that covered her breasts and genitals. She did not draw Eve's face. Danni explained this by saying that she was too far away to have a face. She then worked on the path by putting small paint strokes of color very close together. She fills in the whole path between the two figures using a pointillist style. She then drew a series of green trees in the surrounding space. Having finished the picture, she began to create a dialogue between the two figures. In her dialogue, Eve expressed anger at Adam for not being in contact with her. Eve/Danni stated "You never come, you never come on time." "I have been waiting for hours." "I did the shopping and you didn't come." The dialogue was very animated and included loud tones. At the end of the dialogue, Danni began to cry bitterly and complained that her father was disappointing.

Emergent conflict indicators

The following indicators emerged as descriptors of conflict five:

Behavioral indicators of physical development of female sexuality and identity:

- (a) Sexually enhancing behaviors.
- (b) Behaviors of sexual attraction.
- (c) Artistic representations of sexuality.
- (d) Artistic representations of female identity.

Verbal indicators of female sexuality and identity:

- (a) Evaluations of attractiveness
- (b) Statements of undertaken female roles.

Behavioral indicators of the rejection of female sexuality and identity:

- (a) Sexually blurring behaviors.
- (b) Excessive cleaning behaviors.
- (c) Aggression towards own body.
- (d) Artistic expressions of aggression.
- (e) Artistic expressions of ambivalence.

Verbal indicators of the rejection of female sexuality and identity:

- (a) Self-denigration of physical self.
- (b) Rejections of physical contact.
- (c) Aggression towards male figures.
- (d) Rejection of female figures.
- (e) Ambivalence towards art figures.

Conflict six: The need for complete control and the feeling of lack of control

This conflict is present throughout the art therapy treatment of the anorectic patient. The intensity of this conflict varies during the period of treatment. It is connected to the patient's feelings of insecurity, anxiety, and fears. The more heightened the sense of the patients' insecurity, the greater the likelihood of this conflict arising. The most obvious manifestation of this conflict is the anorectic patient's control of food intake. By reducing food intake and taking part in extreme physical activity, the anorectic patient tries to control her own bodily growth and weight. The objective of this control is to reverse physical processes and/or achieve physical thinness as an ideal of beauty. The need for control can also be expressed through the use and development of cognitive abilities. Anorectic patients put enormous efforts into being excellent students at school and in explaining the phenomena that they experience. In many cases, these cognitive explanations seem to be distant from the emotional content that informs them. For example, one anorectic patient explained her own lack of worth by explaining that she was the cause of her mother's chronic illness. The patient had worked out the details of her role in her mother's illness by pointing out that when she was three she had tired her mother out and was a very "bad child." The therapists' questioning of the possibility that a 3-year-old child had the power to cause a chronic disease was not addressed by the patient because she had the right explanation and the therapist did not understand. As in this example, this need for control and rigidity in thought processes can lead to feelings of omnipotence. The anorectic patient exaggerates her own powers in controlling the people and situations within which she is involved.

This conflict arises when physical changes take place and when society makes new demands on them.

These changes create a sense of losing control over their lives and a devaluation of themselves. For example, many anorectic patients refuse to participate in a new project for fear that it won't be perfect and won't meet the required standards. In the art process, this sense of loss of control is expressed by the inability to work with art materials that they cannot control directly. The anorectic patient in this state will prefer to work with pencils or markers and object to the use of paints or any other more liquid color types. These patients may produce images of flying figures, fairies and spirits. What connects these images is the patient's claim that they are spiritual beings beyond the body. These patients also prefer the use of verbal interaction to artistic representation. They express fears that they do not know what can be understood from their artwork. They feel that they have much greater control over the words they produce. The anorectic patient's response to this loss of control is to regain control through food intake and physical exercise.

To exemplify the sixth conflict consider the following vignette:

Ruth started her second art therapy session by choosing to work with colored pencils on the 18'' by 12'' page that she had already started a session before. She stated that she was not good in art and painting. She then drew a small boy. The boy's hand was connected to a line that already existed on the page from the previous sessions doodles. She stated that the line was another snake. She drew the boy's facial features and then erased them. The small figure was left with very blurred features. She then drew a group of three balloons at the top of the page above the boy. The size of both the small boy and the balloons was tiny in relation to the snake on the page that was drawn in the previous session. Ruth stated that the balloons had run away from the boy. I asked how she felt about the balloons running away. She answered "I feel that all control over my body has been taken away" (being in the in-patient ward). She then looked at her doodle pointing out another part of her drawing and said "that reminds me of a shoe." "It reminds me of Aladdin's magic lamp with Aladdin's genie emerging.

Emergent conflict indicators

The following indicators emerged as descriptors of the sixth conflict:

Behavioral indicators of need for complete control:

- (a) Behavioral control of food intake.
- (b) Artistic expression of need for control.

Verbal indicators of need for complete control:

- (a) Expressions of control of food intake.
- (b) Requests for clear explanations.

- (c) Requests for artistic control.
- (d) Statements of extreme powers—omnipotence.
- (e) Statements of precision.

Behavioral indicators of lack of control:

- (a) Resistance to art therapy.
- (b) Artistic expression of lack of control.

Verbal indicators of lack of control:

- (a) Expressions of lack of control of food.
- (b) Expressions of helplessness and impotence concerning art therapy.
- (c) Expressions of helplessness impotence and guilt concerning family relationships.
- (d) Projective expressions of need.

Discussion

In this paper, the disorder of anorexia nervosa has been described by focusing on the underlying conflicts that emerged through the analysis of the art therapy session reports of 10 anorectic patients. In

this context, anorexia nervosa is a complex illness in which there is an interaction among opposing desires and forces on different intra- and interpersonal levels. In the current study, six conflicts were found to be present during the art therapy treatment of 10 anorectic patients. Although the current study was not constituted within any particular theoretical explanation, each of the six conflicts that emerged from the analysis of the data has a strong link to specific theoretical orientations. The relationship between the emergent conflicts and their theoretical underpinnings is summarized in Table 1.

As can be seen in Table 1, across all six conflicts a range of theoretical positions is addressed in describing the disorder of anorexia nervosa. These positions include Bruch's (1970, 1973, 1979, 1985) explanation of anorexia nervosa in relation to powerlessness and control, Freudian explanations of anorexia nervosa as rejection of female sexuality and the relationship of anorexia nervosa to processes of separation-individuation. Essentially conflicts three to six relate to the major explanations of anorexia nervosa. It is important to note that the empirical

Table 1
Summary of theoretical underpinnings of six emergent conflicts

Conflict title	Theoretical orientation
Conflict one: verbal and/or emotional-behavioral resistance to art therapy and attraction to artistic materials and the creative artistic process	Resistance as a central part of anorexia nervosa. Resistance is a basic defense mechanism against internal drives and desires (Boris, 1984; Fischer, 1989; Swift, 1991)
Conflict two: intensive creation of an artistic object and the desire to destroy it	The role of the art object as a transactional object that embodies the conflicts, emotions and associations found in the anorectic patient that may be negotiable. Aggression towards herself is projected onto the artwork and the artwork becomes the object of "scapegoat transference" (Schaverien, 1994, 1987)
Conflict three: the desire and need to be looked after and held and the verbal inability to directly express this desire and need	The desire for a symbiotic and dependent relationship with others reflecting early problems in the object-relation stage of development (Bruch, 1973). The inability to express this desire is related to in Luzzatto's (1994) description of the double bind
Conflict four: the need to be dependent and in a relationship with others and the desire to be autonomous	This need involves issues with separation and individuation in early infancy and early adolescence (Blos, 1967; Mahler, Pine, & Bergman, 1975; Masterson, 1997). Family structure that inhibits separation and individuation can lead to anorexia (Eisler, 1995)
Conflict five: the physical development of female sexuality and identity and the rejection of these physical developments and identity	Rejection of female sexual identity and its physical manifestations is tied to early Freudian explanations of psychosexual development. In anorexia this can be tied to basic drive and defense mechanisms, the onset of secondary Oedipal conflict in puberty (Elizur et al., 1991; Schaverien, 1995a, 1995b; Waller, 1993) or the rejection of a mother's sexuality (Selvini Palazzoli, 1974)
Conflict six: the need for complete control and the feeling of lack of control	The need for control and the feeling of a lack of control has been discussed extensively by Bruch (1970, 1973, 1979, 1984). In anorectic patients food intake and body weight are controlled to counter a basic sense of powerlessness and ineffectiveness

data of the current analysis found evidence for all of these theories. Accordingly, rather than negating one position or another, the analysis of the current data set supports a more eclectic approach to the description of anorexia nervosa. A description of this kind should be able to address the variation in the disorder rather than trying to limit the description to a restricted theoretical position. As seen in the current data set all four of these positions were represented.

Conflicts one and two are a direct result of the setting of the data within the art therapy process. It has already been documented that resistance is a part of the process of treating anorectic patients but what is interesting in the current setting is the way artistic materials interact with this resistance. The willingness of the patient to approach art materials interacts with the actual resistance to treatment. When treatment is through art a conflict such as this can concretely arise. Conflict two provides direct evidence of the embodiment of unconscious material in art and the art process. The desire to destroy the artistic product after putting effort into producing it demonstrates this shift of aggression to the art process.

As seen in the description, vignettes and indicators of each conflict, the art therapy process and art products are a particularly good tool for exposing and treating internal conflicts. The art product and art processing have no difficulty in embodying conflicting and unconscious internal material. The art process makes these internal conflicts concrete and gives them a form that is present within the treatment session. This concrete presence is then open for manipulation and negotiation in the therapeutic process. The art therapist uses the art process and art product in order to bridge the distance between opposing forces. For the anorectic patient, the art process and the art product embodies those conflicting forces that constitute the illness anorexia nervosa.

The process of communication in art therapy with anorectic patients is conducted through the art process and product and this allows the creation of a therapeutic relationship that is not intrusive and which honors the autonomy of the patient. It is the concrete presence of the art process and product that embodies these conflicting forces of the patient rather than the verbal interaction. The anorectic patient has put enormous effort in to suppressing and denying some of these opposing forces. The art process brings these conflicts into the therapeutic process. Once they are in the therapeutic space the split between opposing forces becomes apparent. Therapy takes place through the therapist's negotiation and direction of the relationship of the anorectic patient to the art process and product. The patient's recognition that internal conflicts exist and that the art therapist does not reject the patient as a result of their presence is a central

aspect of treatment. This concretization of conflicts, acknowledgement of the presence of internal conflicts and the reduction in intensity of the forces that make up the conflict, reduces the resonance of these conflicts within the patient's mind. Rather than invading her every thought and action, these conflicts are seen in more moderate proportions. In the short-term, this keeps the anorectic patient alive and allows her to address these conflicts and thus, in the long-term, to partake in the maturation process.

Final comments

The aim of this paper was to provide a description of the eating disorder anorexia nervosa that was directly situated within the art therapy process. The current paper followed a qualitative approach to research and explored the disorder anorexia nervosa by analyzing in a detailed, systematic and in a cyclical manner art therapy sessions summary reports. The results describe the disorder through a series of six conflicts. These conflicts embody a wide range of theoretical orientations and suggest that the description of anorexia nervosa needs a wide based eclectic approach. Future research is needed to transform these conflicts into a diagnostic and therapeutic tool. The current paper is an initial stage that offers art therapist the building blocks of a theory of anorexia nervosa that is directly situated within the art therapy process.

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