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The mirror within: An art therapy research project identifying the links between anorexia nervosa, object relations and the potential role of art as the transitional object

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THE MIRROR WITHIN:

an art therapy research project identifying the links between anorexia nervosa, object relations and the potential role of art as the transitional object.

BY

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Submitted in partial fulfilment of the requirements for the degree of Master of Arts.

(Art Therapy)

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November 1997.

ABSTRACT

This research focuses on the use of art therapy with female teenage clients suffering from anorexia nervosa. The aim was to undertake a pilot study that would establish whether art therapy could assist in identifying anorexic clients' ego boundary delineations using an object relations framework (That is, either enmeshed, inter related or isolated).

Utilising Elkisch's picture analysis procedure, client art works were analysed by contrasting positive and negative characteristics as a way of gaining insight into the client's boundary delineation cognition. Five female subjects aged between thirteen and sixteen, who were taking part in the eating disorders program, located in a large teaching hospital in Western Australia, took part in one hour group art therapy sessions, that were held over a three week period.

Paralleling this process, a group made up of a similarly demographic population, deemed to be non anorexic took part in an identical art therapy program. Their art works were used as a means of comparison for this thesis.

This study attempted to answer the question "Can art therapy be used as the measure for determining difference between the art works of the female teenage clients with anorexia from the art works that the female teenagers without anorexia when viewed within an object relations framework?"

Findings from this study would suggest that using art therapy as the measure for determining anorexia amongst clients proved to have an 80% success rate in the areas of both specificity and sensitivity. The most significant differences to emerge were: use of

space, ability to create art works with a positive or inviting feel, ability to respond to task, ability to include a variety of themes in picture construction and the significance of the environment in which the central image is placed.

Given that review of this experiment does not include post drawing discussions of art works made, nor does it annotate client approach to the art tasks, the experiment was still able to clearly indicate differences between the artworks of clients with anorexia and that of control clients.

The outcomes of this study suggest that art therapy may have a significant role to play in the identifying of anorexia amongst potential clients and could be used successfully as an adjunct to present assessment procedures used, because of it's ability to produce different yet significant material not able to be gleaned through current procedures.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signature

Date. 26.3.98.

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BRONWEN GRAY

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INTRODUCTION

1.1 The Background To The Study.

This study was an attempt to identify whether anorexia nervosa can be effectively assessed using an object relations framework and to explore how art therapy might act as a bridging process, through which the anorexic may gain insight into their condition and lives.

For the first part of 1997, it was my privilege to undertake a placement in an Eating Disorders Unit that has been established in a local children's hospital in Perth, Western Australia. (Appendix A.) The clients I worked with were all female and aged between thirteen and sixteen years of age, and were taking part in the eight week eating disorders out-patient program that the hospital has developed.

I have always believed that intrinsically, we all end up in places or situations in our lives because we are supposed to learn or take something from these experiences. In recognising this belief whilst undertaking this placement, I was keen to track my own journey to see what it was that I would learn about myself. As someone who has watched friends and colleagues, and often myself, battle with self identity and its relationship to our weight, I had thought that the lesson I would learn from being placed in this section of the psychiatric department was in some way related to learning how to integrate a stronger sense of self, devoid of body size obsession.

Yet instead, what I realised I was being drawn to investigate, was how the concepts of object relations that I had learnt about in class actually applied to clients and their experiences. Each week as I watched the clients battle their desire to eat, making bargains

with themselves over when and how much food they would allow to pass their lips, I realised that I was involved in a parallel experience involving my three year old daughter.

She does not have an eating disorder, but I was amazed at how my experience at the hospital was in some way mirroring hers. At an age when most children choose to exercise their right to an independent sense of self from parent, I was intrigued to discover how often the battle ground for my daughter's struggle revolved around food, when and how to eat, what to eat and where. How quickly I learnt to participate in these games, often unwittingly, participating in the push and pull that marks this first stage of separation that is defined within the concepts of object relations.

Again to pay homage to this natural and necessary process that all children and parents must go through, it is fitting to use the metaphor of the mirror: to watch and to be watched. As children we watch ourselves unselfconsciously, naturally and with much enjoyment and curiosity. The mirror is our friend and our teacher. Winnicott (1988, p. 100) says "There is much that could be said that has to do with the baby's use of the mother's face. It is possible to think of the mother's face as the prototype of the glass mirror. In the mother's face the baby sees him - or herself." Satter (Clark, Parr and Castelli, 1988, p. 8) refers to feeding as a mirror for the relationship. She notes that the type of interaction displayed in feeding, mirrors the overall parent- child relationship. She writes,

Ainsworth and Bell (1969) have found that mothers who allowed their babies to actively participate in feeding scored higher on the variables of maternal care - realistic perception of the baby, delight in the baby, acceptance of the baby, appropriateness of the interaction, amount of physical contact, and effectiveness of response to crying.

Within the confines of object relations, we often talk about the task of the mother being one where she is able to mirror back to the child in its early formative years, actions, sounds and movements as a way of developing positive self regard.

Just as the child, at the stage of separation/individuation, is able to split bad experiences from good (Ogden, 1983, p. 229), for many teenagers the mirror actively reflects this process. The mirror becomes an active metaphor for the bad - their worst enemy, their worst critic, yet something that they cannot tear themselves away from. As noted by Gordon (1988, p.147) when referring to teenagers with anorexia, "Daily these human beings view themselves in the mirror with feelings of fear and trepidation, dreading any sign of fat. Eating, yet not eating - their lives and behaviour have been organised around food intake".

When discussing teenage anorexia, Wolf, Wilmuth and Watkins (1986, p.44) state,

Writers from a variety of theoretical perspective's agree that anorexia nervosa represents an attempt to solve a psychological issue or conflict through the concrete manipulation of food intake and body shape. . . Sours (1980) identifies the central issue of the anorexic as a failure in the developmental stage of separation/individuation, in line with Mahler's theoretical and observational work. . . Sours posits further that separation/individuation issues reoccur during adolescence, the anorexic unable to work these through to completion because of the earlier developmental failure.

Accepting Sour's suggestion that separation/individuation issues reoccur during adolescence, then our task as adults (whether anorexic or not) in working through these issues, is to heal the split. We need to internalise the possibility of the mirror being able to

convey both the good and bad, enabling us to re-find those child like qualities that allow us to play in front of the mirror again. We must rediscover that sense of bliss that we experience as children, attached to our mothers symbiotically, before we noticed the mirror in the corner.

It was within this context that I started to understand how the condition of anorexia nervosa may be better understood through the use of an object relations framework and, how the art being made by my clients might reflect this connection.

1.2 The Significance Of The Study.

1.2. "In recent years, anorexia nervosa has been identified as a major psychiatric illness, primarily affecting women." (Crowl, M 1980. p. 141) In support of this statement, Hobbs and Johnson (1996, p.1273) believe that dieting has now reached epic proportions and identified that by age eighteen, more than fifty percent of girls perceive themselves as too fat, despite having normal body weight. The marked increase amongst western women in health problems surrounding dieting and anorexia nervosa has generated a growing body of research into the issues related to the possible causes and potential cures for the condition. It should be noted that within this body of research, there is still very little material that documents or explores how art therapy can be used effectively as a treatment modality when working with these clients. Most of what is available has been reviewed as part of this study.

Given that the condition manifests itself essentially through non verbal activities (the unwillingness to eat) it seems important to look at the role art therapy - predominantly a non verbal therapy - can play in helping the client to come to a clearer understanding of what the illness means for them.

1.3 The Purpose Of The Study.

1.3.1. Aim of the study.

To undertake a pilot study that will establish whether art therapy can assist in identifying the ego boundary delineations of clients with anorexia (that is either enmeshed, inter related or isolated) using an object relations framework.

If in fact art therapy can be used as a way of identifying the boundary delineations of teenage clients with anorexia, then it may be possible to develop an art therapy modality that can accompany assessment procedures presently used with these clients classified under these headings.

1.3.2. Objectives.

(A) To use Elkisch's picture analysis procedure as an instrument, to contrast positive and negative characteristics of client's art works, as a way of gaining insight into the clients' boundary delineation cognition.

(B) To compare the art works of clients with anorexia with art works produced by young women of a similar age, who are deemed non anorexic, as a way of assessing the similarities and differences in the art works produced.

1.4 The Research Question.

1.4. This thesis addresses the question "Can art therapy be used as the measure for determining difference between the art works of the female teenage clients with anorexia

from the art works that the female teenagers without anorexia when viewed within an object relations framework?"

1.5 The thesis hypothesis.

1.5. The art work of clients with anorexia will be able to be clearly identified from those participants without anorexia, through their use of imagery, lines, colours, spatial abilities and approach to the task. Their art works will demonstrate either enmeshed or isolated boundary delineations when compared to the art works of control clients, which will demonstrate a more inter related approach to boundary delineation.

1.6.1 Definition Of Terms (general)

Anorexia Nervosa: (A). Refusal to maintain body weight at or above a minimally normal weight for age and height (eg, weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

(B). Intense fear of gaining weight or becoming fat, even though underweight.

(C.) 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.

(D). In postmenarcheal females, amenorrhea, ie, the absence of at least three consecutive menstrual cycles. (DSM IV, 1994, p. 251)

Art Therapy: A symbolic language that provides access to unacknowledged feelings and a means of integrating them creatively into the personality, enabling therapeutic change to take place. (Dokter, 1994, p. 3)

Ego Boundary: That which gives a sense of the distinction between oneself and external objects (St Clair, 1986 p.188)

Object Relations: A collection of theories that examine interpersonal relations, whether external to the individual or as represented within the individual's psyche. (Klein et al, 1992, p.27.)

1.6.2 Definition of Terms - Object Relations.

Depressive position: state where the baby realises that the good mother that feeds it is the same mother that they hate when angry and frustrated. This realisation brings feelings of guilt and concern at the aggression and phantasised attacks that they carried out to those they love. (Passey, 1994, p.177)

Enmeshment: Extreme form of proximity and intensity in interactions with others leading to poorly differentiated subsystem boundaries.

(Vandereycken, Kog and Vanderlinden, 1989, p. 194)

Inter relatedness: An understanding of self as separate, and able to interact with the world and other people in a sincere and meaningful way.

Isolation: The condition of being isolated and consequently to disengage with the outside world.

Paranoid-schizoid position: A persecutory anxiety state which threatens to and often fragments the mind. Its severity affects the move onwards into the depressive position, because the integrity of the mind is severely disrupted. The splitting processes leads to projection of parts of self or ego (projective identification) into objects. (Hinshelwood, 1994, p. 156)

Separation/Individuation process: The establishment of a sense of separateness from, and relation to, a world of reality, particularly with regard to the experiences of one's own body and to the principal representative of the world as the infant experiences it, the primary love object. (Mahler, 1975, p3.)

Symbiosis: infantile phantasy in which the child believes that it and its mother are fused in a dual entity with a common boundary. (St Clair, 1986, p.191)

Transitional Object: An object which is understood to be a means of negotiating and mediating between the internal world and the external environment. (Winnicott, 1971, Schaverian, 1994.)

1.6.3 Definition of Terms - Elkisch's Projective Techniques With Children.

Rhythm v's Rule:

- Rhythm involves flexible strokes that show a free, relaxed movement with a pleasingly proportional distribution of an object.
- Rule indicates a tight spasmodic movement often done mechanically.

Complexity v's Simplicity

- Complexity refers to a complete or detailed drawing.
- Simplicity is a lack of detail and impoverished differentiation that suggests regression or fixation in earlier stages of development.

Expansion v's Compression

- Expansion reflects a sense of spaciousness in the drawing.
- Compression gives the feeling of meticulous smallness or the experience of being closed in.

Integration v's Disintegration

- Integration provides a feeling of the whole with things in place, demonstrating an ability to relate, combine and organise.
- Disintegration represents sloppiness and the use of unrelated and disconnected objects, so that a sense of oneness is not evoked.

2. Review Of The Literature.

The background reading for this thesis has led me to investigate literature related to anorexia nervosa, object relations, parenting, feminism, youth, and where possible these topics linked to art therapy.

2.1 Anorexia nervosa.

Anorexia Nervosa is an illness that usually starts in the mid teens and has a prevalence rate of 0.3%, which equates to 2 people per 100,000 in the general population. The group deemed to be most at risk is school girls and female university students, with the prevalence rate for this client group being between 1%- 4%. (McDermott, Forbes & Gillick, 1996, p. 1) Nearly always, anorexia begins with everyday dieting, but instead of stopping the dieting when the desired goal weight is reached, the dieting and weight loss continue until the sufferer is well below the normal limit for her height and age. (Dokter, 1994, p.10) Although not exclusive to women, it is more likely to affect women than men at a rate of ten to one (Levens, 1987, p.2). A description of the condition is expanded upon by Mahowald, 1992,p. 236.

Although the term anorexia literally means lack of appetite, in fact anorexics usually crave food, but deny themselves because of their unfounded fear of fatness.

Because concern about diet and weight gain is so widespread among relatively healthy people, the severity of the disease may be overlooked. Consider, however, this sobering statistic: mortality rates range between 5% and 18%.

McDermott et al. (1996, p.1) add that with regards to these mortality figures, 50% of these anorexics will die of malnutrition, and 50% will suicide. They continue by reporting that anorexia is known to be the third most common chronic illness in teenage girls.

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) defines Anorexia Nervosa as -

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (eg, weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. 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.
- D. In postmenarcheal females, amenorrhea, ie, the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, eg, oestrogen, administration.)

Known as the 'starving disease', anorexia nervosa is characterised by " dramatic weight loss, an intense fear of becoming obese, a disturbance of body image and a refusal to maintain body weight normal for age and height" (Chassler, 1994, p.399). Physically speaking, the medical complications vary from cardiac arrest, kidney failure, dry, pale skin, swollen salivary glands, erosion of tooth enamel and are the result of the body's attempts to conserve energy, unyielded through caloric intake. (Hobbs and Johnson, 1996, p.1278)

Cognitive complications range from food preoccupation, impaired sleep, decreased libido , and poor concentration, with the client often experiencing extremes in emotions ranging from euphoria to extreme depression and personal isolation. (Hobbs and Johnson 1996, p. 1278)

Within the Medical profession, it is generally accepted that anorexia nervosa has its roots in psychological disturbances which cause mental, emotional and physical deterioration. (Chassler, 1994, p. 401) but it is also increasingly accepted that no one model can account for the range of symptoms that manifest in patients with the illness. The earliest treatment plans tended to deal only with the oral or feeding components of the illness, but more and more the medical profession takes into consideration the family and socio specific conditions of the client as well as the biological factors.

Although seen in growing proportions in modern western society, anorexia nervosa has been in existence for many centuries. The form these disorders took at different times through out history varied, as did the motivation for the behaviour. Significant though to all was the theme of "hunger strike" amongst women where personal wishes and other forms of inedia reflected women's status throughout history and their potential social roles. Bomporard (1996, p. 231) a professor of clinical psychiatry believes that "the control of food intake and the image of the body have served as the basis for the expression of female needs or of female psychopathology at least since the Middle Ages."

In the twentieth century, anorexia began to increase in the 1950's and reached a peak in the 1970's. (Erichsen, 1985, p.17) Hobbs and Johnson indicate the increasing role of the media, in particular, its association of thinness with power. Their findings reveal that "By age 18, more than 50 percent of girls perceive themselves as too fat, despite having normal weight."(1996, p.1273)

Baluch, Furnham and Huszcza (1997, p. 168) continue further by noting that there is also a growing concern about body shape, physical attractiveness and dieting amongst younger teenagers. In particular this trend was indicated in studies undertaken by Green and McKenna (1993) with fourteen year old females. Suggested in their work is an understanding that maturational factors should be linked with the onset of eating disorders.

There is no one reason why a client develops the condition anorexia nervosa. Sufferers stories are all unique, and the only thing that we can be absolutely sure of is that eating disorders are not about food. As with many psychological disorders, the anorexia may be the presenting issue, but underlying this, intense emotional distress is often being signalled. Feminist psychotherapist Orbach recognised that female clients with anorexia were using their bodies to express difficult emotional issues and suggests that "We need to understand why it is safer to say "I need to go on a diet" than "I feel hurt or upset or in conflict." (1989, p. 3)

Buckroyd (1989, p34), also a feminist counsellor, who works predominantly with dancers suffering with anorexia suggests

Our experience with food does not necessarily turn us into food misusers, but it does give us a language, a way of behaving, if we get to the point of feeling that we have to use it. It gives us weapons, ammunition of a certain kind, if we need to take them up. What we need to do now is to explore what reasons there might be for us taking up these powerful weapons

Anorexia nervosa usually starts in the teenage years and is predominantly, though not exclusively a female problem; with high mortality rates. It is characterised by refusal to

maintain body weight, refusal to gain weight, denial of decreasing body size, and amenorrhea in post menarcheal females. Although it has existed for many centuries in endemic proportions, which may be due to many factors, the media perhaps the most significant. When examining the condition of anorexia nervosa, it becomes important to recognise that although the condition manifests itself in the form of extreme dieting, affecting the body and physical appearances, the use of the body in fact signals far greater internal or psychological turmoil that clients lack the ability to express verbally. This in itself is as important to respond to as are the eating patterns of the client.

2.2 Object relations.

Object relations theorists investigate the early formation and differentiation of psychological structures (inner images of the self and the other, or object) and how these inner structures are manifested in interpersonal situations (St Clair, 1986, p. 2).

Tuttman (1992, p.241) identifies that "object relations is not a single theory but a broad and complex area of psychoanalytic thought. It is therefore more accurate to speak of object relations theories." In line with this observation, object relations approaches to anorexia nervosa are also broad and complex, but consequently provide a rich overall framework in which anorexia can be viewed

A number of psychoanalyst's contributed to the rise of object relations theory. Amongst these analysts, Klein identified the capacity of the individual to internalise contact with other human beings and that the psyche develops as a response to emotional contact with others. Klein's view of the development of the psyche differed significantly from Freud, with whom she worked with for a number of years, who believed that the psyche developed as a response to the regulation of instinctual drives. Obernbreit, (1981, p.57)

Fairbairn, a Scottish psychoanalyst, whose work in the field of object relations developed as a response to the work of Klein and Freud, believed that humans have a basic drive toward relating with other people (St Clair, 1986, p. 54). In explaining Fairbairn's theories, Rice (1992, p.31) states "He considered the ego at birth to be in pristine if undifferentiated form, having the primary task of negotiating the relationship between the self and reality, including the external objects such as the mother." Rice continues by saying,

Development in Fairbairn's system reflects his interpersonal emphasis. He identifies two developmental stages: (1) infantile dependency, when the infant is totally dependent on others for physical and emotional survival, and (2) mature dependency, when one can establish mutually interdependent relationships.

Between those two stages is a transition period in which individuals gradually separate from their primary care givers until they are able to establish interdependent relationships.

Underpinning this process is the understanding that the child originally joins in some meaningful way with the care giver and reaches a stage where he or she feels comfortable enough to move away from the mother and experience other aspects of his or her environment. Implicit in this process is the child's understanding that he or she can return to his or her mother as needed in a way that moves the relationship into a period of interrelatedness, rather than a phase where either the child or the parent is solely dependent on the other for his or her sense of self.

Paediatrician and psychoanalyst Winnicott, emphasises the physical/psychological significance of the " holding environment" between mother and child in the child's

development and in the establishment of the baby as person. (1988, p. 96) Crucial to this is, metaphorically speaking, an understanding of the mother's face and role is to act as a mirror for the child, in which the baby sees reflected back an image of self. Through this mirroring process, the child experiences reassurance, leading to healthy ego development and is able to tolerate the idea that objects can exist separately from themselves. (1971, p.112)

Tuttman (1992, p.244) states "Winnicott also noted the need for "good enough" mothering and observed that when the parent is sufficiently caring and understanding, but not intrusive, the dependent child dares to express the developing self spontaneously."

Central also to Winnicott's contribution to object relations was the defining and use of the term transitional object. He described it as "a symbol of the available object (in this case the caretaker) upon which the dependent child relies." (Tuttman, 1992, p.244). Winnicott believed that the transitional object is symbolic of the trust and union between baby and mother, a union which involves no interpretation." (1988, p. 100)

Writers in the area of early childhood development understand that the child will eventually separate from its parent, Nevertheless they point out a necessary pre condition. For example, Winnicott (1975, p.33), refutes the theory of 'training' a baby as early as possible, on the grounds that the infant first needs to experience a stage of acceptance of the outside world; a stage precipitated by the mothers initial compliance with the child's desires.

Winnicott (1975, p. 34) goes on to say

In other words, the only true basis for a relation of a child to a mother and father, to other children, and eventually to society, is the first successful relationship between the mother and baby, between two people, with not even a regular feeding rule coming between them, nor even a rule that baby must be breast fed. In human affairs, the more complex can only develop out of the more simple.

Schaverian (1989, p. 14) elaborates on Winnicott's concept of the mother/infant relationship, stressing the reciprocal nature of gratification involved in the early feeding stage. Eichenbaum and Orbach (1983, p. 22) similarly believe that the child is only able to become independent once he/she has developed the security and confidence that comes from knowing that it can depend upon adults it is close to.

Buckroyd (1989, p.19) takes this argument further by stating that good feeding experiences in infancy are important because they leave us with the memory traces of blissful states which we may later try to recapture.

Suggested in this writing is the understanding that one of the most powerful ways in which the child originally joins with his/her parent is through the means of feeding and in fact nurturing. Whether through contact with the breast, the connection with human skin whilst being bottle fed or constant visual and verbal meetings whilst being spoon fed, the child's first demand on parent when entering the world is for food and nurture. Once responded to and connected with only then is the child able to move on to the next psychological stage of his/her life, the stage of initial individuation.

Physician and psychoanalyst Mahler contributed to the theories of object relations by expanding on much of the previously mentioned, through the development of the concept of psychological birth of the individual. Her view defines the process by which the child

learns to separate from his/her primary care giver (in most cases the mother) in an environment that encourages self awareness and individuality.

Mahler, Pine and Bergman as cited by Chassler (1994, p.404) state that they saw

separation - individuation as an intra psychic process, a psychological achievement in . . . "the establishment of a sense of separateness from, and relation to, a world of reality, particularly with regard to the experiences of one's own body and to the principal representative of the world as the infant experiences it, the primary love object. (p.3)"

This stage of psychological development, separation/individuation, generally begins at four months of age and completes between thirty and thirty six months. It is understood that how well the parent allows the child to move between being interconnected through to interrelated will determine future patterns in relationships developed at later stages in life.

Prior to the stages of separation and differentiation, Mahler believed that the infant was emotionally symbiotically linked with his/her mother, unable to differentiate itself and that accordingly, the infant's personality also begins in a state of psychological fusion with this caregiver. Gradually, the child is able to separate from the caregiver, through a series of psychological processes, characterised by symbiosis, separation and differentiation, practicing and reproachment, leading finally to individuation. Mahler also believed that "the unfinished crises and residues of the earlier symbiotic state as well as the process of separation and becoming individuated influence relationships over a lifetime". St Clair (1986, p.106)

If the child is not encouraged to individuate at this age hence developing its own sense of self as interrelated, the child often forms future patterns in relationships that suggest enmeshment - where the boundaries are unclear and the child feels incapable of understanding himself/herself as separate. At the other end of the spectrum, if the child is pushed away from the parent too quickly and feels unable to return from time to time as needed, it may form future patterns in relationships that suggest isolation, or disengagement, an unwillingness or inability to be truly in touch with others.

Satter recognised that the teenagers pre-learned boundary delineations may in fact be indicative of the boundaries that all family members may have developed. In referring to family relationships whilst discussing teenage anorexics she suggests the over-protective family limits the child's autonomy, whilst the chaotic family doesn't protect enough and concludes "The over-protective, enmeshed family becomes rigid. . . The disorganised, chaotic family simply cuts all controls". (1988, p. 10)

Although taken from within the philosophies of the family therapy movement, these ideas have much insight to offer into the life of the anorexic when viewed in association with an object relations framework. It could be argued that the primary relationship between child and mother is in fact the child's first understanding of the family system in which it will have to operate, and as Mahler suggests, is the precursor for future relational interactions.

In line with this thinking, St Clair (1986, p. 107) continues

Individuation and identity formation presuppose structuralisation of the ego and the neutralisation of the drives. Stimuli must not be so overwhelming as to prevent the formation of the structure. In the absence of the inner organiser, the mother has to serve as a buffer against inner and outer stimuli. Structuralisation is promoted by a

sequence of gratification and frustration. The mother serves as the auxiliary ego for the infant by providing gratification of needs and preventing excessive frustration. Her various holding behaviours keep tension and frustration from becoming too great and prevent the infant from prematurely developing its own resources.

Mahler, Pine and Bergman (1975, p.110) in discussing how they believe the child's personality develops write "(the third year of life) is an extremely important intrapsychic developmental period, in the course of which a stable sense of entity (self boundaries) is attained."

Object relations theories represent a complex series of psychoanalytic thoughts, that developed as a response to Freud's belief in instinctive drives that determined how individuals related to one another. Object relations theories recognise that individuals have the ability to internalise contact with others and that the psyche develops as a response to these emotional contacts. Object relations pays particular attention to the relationship of the child to its primary caregiver and stresses the importance of encouraging the child to determine its need for clear boundary delineation between self and others and the role that transitional objects can play in this process. Of significance is how well the parent is able to mirror back to the child a clear sense of self, others and positive self regard.

Through the healthy delineation of boundaries, the child develops a sense of security, realistic self concepts and the capacity for empathic understanding of others (objects). The significance of this primary relationship and the process of moving from a state of symbiosis through to separation/individuation has impact on the child's ability to trust others, form meaningful relationships with self and others in the future and will determine patterns of interactions with others in the child's future.

2.3 Anorexia Nervosa and Object Relations.

"Anorexia nervosa is a baffling, disturbing and intriguing syndrome. Comprehending its meaning requires knowledge of biology, sociology and psychology. Each of these frames of reference contributes different and at times conflicting perspective's." (Garner and Garfunkel, 1985, p.55) Whilst it is just one of many possible psycho dynamic frameworks through which anorexia can be viewed, object relations has the potential to offer insights into the thinking of the anorexic client, their relationship with food and more importantly, their relationships with others.

Palazzoli, an Italian psychoanalyst, with over forty years of experience in working with anorexic clients, initially identified anorexia as a "disturbance of 'body cognition', an inability to identify or distinguish between different inner states, impulses and desires" (Macswen 1993, p. 45). Palazzoli believed that because of the anorexic child's original experiences with the primary love object (that being the mother or food equalling mother) at the stage of separation/individuation it did not develop the ability to distinguish itself as separate from mother. This experience lead to a splitting in the child's mind, that manifested itself through the internalisation of their body as a 'bad' object. In its attempt to separate.

The body of the anorexic does not merely *contain* the bad object but . . . *is* the bad object. . . the body is experienced as having all the features of the primary object as it was perceived in a situation of oral helplessness: all powerful, indestructible, self-sufficient, growing and threatening. . . there is an unconscious feeling that the object is far too strong to be destroyed. (Palazzoli, 1978, p. 87)

Klein described these early experiences of splitting feelings into 'good' or 'bad' experiences as the paranoid/ schizoid position, and believed they were the result of the immature ego's inability to tolerate or contain together such feelings. As cited by Passey, (1994, p.176) Klein believed that

The good feelings maintain the baby's sense of being part of the mother who is wholly good. The bad, aggressive or destructive feelings which arise out of hunger or frustration are got rid of, projected and are therefore experienced initially by the infant not as belonging to them, but as coming from outside.

In taking this argument one step further, Palazzoli believed that the notion of the mother as bad object became fused with the body itself and that it is at the onset of puberty that this is then realised.

Object relations theorist and psychoanalyst Masterson believed that anorexics experienced arrested development at the separation/individuation stage of development, but linked the arrested development to defects in the ego. Masterson believed that anorexic behaviour was a result of distorted self and object representations, leading towards a borderline personality disorder. Masterson also believed that anorexic children were the result of mothers who also experienced borderline personality disorders. Believing that the anorexic is 'haunted' by both positive and negative introjects, Masterson's view was that the anorexic splits it's feelings, recognising any attempt at separation as the response of a hostile, negative or rejecting maternal introject and sees supportive or positive maternal introjects as the response to dependent clinging behaviour on the part of the child. (Chassler 1994, p. 405)

Buckroyd (1989, p. 23) elaborates on this argument, Paralleling the process of individuation with the use of food as the tool or the catalyst for this task, in which both the

child and the parent actively take a part. Food becomes the active metaphor for the struggle that is taking place. She states,

Parents, especially mothers, can have too much invested in getting their child to eat everything up. Not eating can too easily be seen as rejection of what has been offered and therefore of the one who offers it. . . . It seems an appropriate acknowledgment of the fact that it's easy for mothers to feel rejected and upset over children's eating behaviour, and easy to be over invested in whether the little one eats her egg. In this sense of rejection lie the roots of the anger and the power struggle that so frequently follow a child's refusal of food.

Implicit in this statement is the understanding that food, originally the giver of bliss, becomes the conveyor of tension and more importantly power that the parent is sometimes unwilling to relinquish

Sours(1980, p. 87) in taking Masterson's theory of linking defects in ego with poor self object differentiation, believes that the anorexic fails to develop self and object constancy. In his book, "Starving to death in a sea of objects", Sours suggests also that anorexics prior to restoration of nutrition, are not inclined to report affects, memories or phantasies and are not inclined to participate in therapeutic alliances. (Garner and Garfunkel, 1985, p.59) Within an object relations framework, Sours believed that it became the role of the therapist to become the external ego or transitional object, replacing food or food refusal, of this power.

Wolf, Wilmoth and Watkins (1986, p.44) acknowledge that writers from a variety of theoretical perspective's agree that anorexia nervosa represents an attempt to solve a psychological issue or conflict through the concrete manipulation of food intake and body

shape. Sours (1980, p. 286) identified the central issue of the anorexic as a failure in the developmental stage of individuation/separation, and believed also that during adolescence, separation/individuation issues re-emerge for these clients. Noting that this initial stage individuation occurs before the child has developed linguistic abilities, Sours believed that the teenage anorexic will have difficulty in re-working through these issues, because it lacks the ability to verbalise it's concerns, due to the earlier developmental failure.

Feminist psychoanalyst, Orbach (1986, p. 45) continues by suggesting that not only is anorexia a protest, symbolic of emotional needs, but is also a language for 'problems' which cannot be consciously articulated. She states in *Hunger Strike* (1986, p. 45), "The capacity to experience oneself as a separate person, as a subject (to individuate) rests on the gratification of early dependency needs."

In summing up the importance of working within the object relations framework, when working with this client group, Goodsitt (1985, p.58) argues that anorexics actually view their bodies as the battleground of the separation/individuation war. Goodsitt (1985, p.58) also suggests that anorexics "fail to relate inner experiences because they have an impaired capacity to live within the body self. They are out of touch with their core experiences." (Garner and Garfunkel, 1985, p.60) His belief is that anorexics need to get in touch with these feelings, but lack a language for talking about themselves.

In relation to these ideas Tuttmann (1992, p.249) believes that group centred therapy, utilising an object relations approach is particularly applicable when working with clients who have had difficulty in experiencing positive self definition and relationships with others. The group process offers these clients the opportunity to "express and communicate underlying fantasies, impulses, wishes and fears. An *observing stance* of self and others

can help towards insight and understanding, more objective awareness, and better reality testing." (ibid.: p. 246)

Rice (Klein et al. 1992, p. 39) describes the phases which clients participate in, when working in groups, under the umbrella of object relations. Initially he describes the beginning phase, where the leader recreates a state of normal symbiosis, that will enable inner self object organisation. Implicit in this phase is the understanding that the leader will provide for all the needs of the members. Goodsitt (1985, p. 60) intimates that this includes the therapist taking over the responsibility for the feeding of the clients, both literally and metaphorically, stating that although the client initially protests, they are relieved and are then able to enter into the therapeutic process. This phase of the group also allows members to experience 'object anxiety' by placing them in a situation that demands they meet and interact with strangers, allowing them to develop boundary delineation between themselves and others. At this stage, the therapist is idealised by group members.

The second phase of the group referred to as the structure and protest phase demands that the client no longer idealise the therapist and must experience a larger degree of unpleasantness, possibly even fear and disappointment, neither protecting the members or fulfilling their fantasies. This unpleasantness is possibly manifested in the idea that the client becomes aware that food neither fulfills or maintains their fantasies to which it has previously been attached. Rice (1992, p. 42) says,

The relationships of the members to the leader, and later toward each other, reflects the inner object structures of the paranoid position. . . splitting good and bad self - and object images. Good objects are embraced and bad objects are avoided. Intrinsically reorganisation is called for.

Finally the phase of structure and maturity develops, where "the process of reparation and integration is the means by which the members repair the fractured structure of the group and heal those who have been injured." (Klein et al, 1992, p. 41) This phase develops and replicates what Mahler called the rapprochement sub phase, both of which lead to object constancy. Rice continues,

In the mature phase the structure of the object relations not only includes the integration of bad and good objects, and a flexible differentiation of self and other, but the object relations also becomes triadic and not simply dyadic, and genuine intimacy becomes possible in contrast to the illusion of intimacy at the beginning.

When referring to the condition of anorexia nervosa, most object relations theorists believe that the central issue for the client lies around unresolved issues that have their roots in the separation/individuation stage of development, and agree that anorexia nervosa represents an attempt to solve this issue through the manipulation of food intake. Anorexics lack self object differentiation and object constancy and have developed that ability to split objects into 'good' or 'bad' objects to rationalise their feelings. Recognising that the stage of separation/individuation has its roots in a preverbal stage of development, when issues of separation/individuation re-emerge in adolescence, the anorexic client lacks the ability to re-work through this stage because of the lack of appropriate language necessary to articulate their concerns. Food, originally used to convey attachment becomes the battleground for separation.

2.4 Anorexia nervosa, object relations and art therapy.

Patients with anorexia nervosa frequently present special difficulties in both individual and group psychotherapy, because of their difficulty in verbalising their experiences and

thoughts. In attempt to overcome these difficulties, a number of therapists are turning to alternative therapies, such as art therapy, because it offers the client a way of expressing issues through non verbal communication. Conroy, McDonnell & Sweeney, (1986, p. 322.) believe that " Art therapy offered a possible medium through which patients could begin to talk about their problems".

Art therapist Haeseler (1981, p. 49) through her work with inpatient anorexics found that patients with anorexia were particularly responsive to art therapy and appeared to relax and enjoy the creative outlet it offered them, during hospitalisation. "Patients learn a sensitivity to their own rhythms, energy and mood, as shown in their lines, shapes, colour and themes."

Occupational and Art therapist, Levens continues this argument by noting that if viewed within the framework of object relations, the condition of anorexia nervosa has its origins in the preverbal stage of physical and psychological development and suggests that there will be little achieved by pursuing verbal therapy treatments only with anorexic clients. In recognising the disconnection or split these clients experience between their minds and bodies, she noted that over intellectualisation is a common defence amongst this client group. Imagery, she believes can be less easily manipulated, and the very act of making art involves the client in a spontaneous, creative process, often expressing unconscious feelings. This in itself offers the client a new experience, given that the act of food denial has often involved them in careful planning, both physically, mentally and emotionally. (1987, p.6) She says;

The use of art in the therapeutic process is a viable alternative to verbal language, in that it may bypass the verbal defences of patients with eating disorders, many of whom are well educated and articulate, and may instead encourage a more

appropriate form of communication for that pre verbal area to which many of their problems belong. (1995, p.103)

Mitchell (1980, p. 58) suggests that art work offers a less threatening means for expression for the anorexic than verbal expression. Mitchell believes also that it can be used as a valuable means of gaining self awareness, something that many therapists believe anorexics lack. As cited in Wolf, Wilmuth and Watkins (1986, p. 39) "Bruch (1973) suggests that art therapy be used as a means of stimulating the anorexic's awareness of feelings, since such patients find it difficult to recognise and acknowledge their feelings." Wolf et al. (1986, p. 45) in recognising the role of art therapy in the treatment of anorexia nervosa continue this argument by stating

The picture may express what the patient lacks words to describe. The anorectic perceives herself as lacking psychological boundaries, or with vague undefined physical boundaries, and may feel that her words are potentially dangerous, uncontrolled in their potential to invade others' space as she feels her own has been invaded. Pictures and sculptures, however, are "safe" means of expression because those objects have concrete tangible boundaries.

In her latest work, Levens (1995, p.44) describes the anorexics inability to function in an inter-related way. She refers to the neutral zone between fusion and separation as an 'in-myself space', which the client deliberately creates within her own body to become her transitional space. The purpose of creating this space is to avoid the inevitable feeling of engulfment that accompanies separation during adolescence.

In explaining the importance of art therapy in resolving this lack of appropriate space she states, "art may be seen as an extension of the self and as a psychological double capable of

mirroring oneself." (1995, p.107) The art allows the client to create an area which is situated between her internal and external realities and the art materials provide the boundaries necessary to hold these new experiences effectively.

Art therapist Schaverian (1989, p.14) takes the argument of using object relations based art therapy with anorexics one step further, by suggesting that in fact the art has the potential to replace food as the transitional object, which the patient presently uses to convey her need for boundary delineation and a healthy inter relatedness. She writes,

For the anorexic, food is significant; it is a symptom, a means of expressing something else and it becomes a medium for relating to the outer environment; a transactional device. In art therapy the art object can fulfil a similar role, it can become the mediator for relating to the outer environment. . . .through the making of pictures she may redefine her existence. In finding another means of expression for her conflicted and divided inner world, the patient may permit herself to eat more normally. . . A freedom and self understanding develops through assimilation of the pictured images. An understanding of the unconscious meanings of anorexia for this individual comes clearer and the need to enact the drama of life through food is gradually relinquished.

Put more simply, M. Warrier (1994, p.24), herself a sufferer of anorexia, says

As strange as it may seem, anorexia and illustration have at least one thing in common. They are both expressing oneself without words, yet one is destructive and the other creative.

Bruch, (1985, p. 18) in describing her role when working with anorexics stated that their task was "to discover their creative and human potential, and to give up the hateful, unlovable, empty, and defective self image that underlies the illness."

In this view during adolescence, issues surrounding separation and individuation re-emerge and require that the adolescent deal with these concerns as part of their struggle for self identity, separate from previously understood internal and external objects. For the anorexic client, this task often proves to be difficult, because of an arrested sense of self as separate from others, the roots of which lie in the pre verbal stage of initial individuation/separation. This inability to deal with the re-emergence of these issues manifests itself in the anorexic condition, where the client allows their food refusal to 'speak' on their behalf.

Art therapy, which in itself is predominantly a non verbal therapy can take the role of the transitional object for these clients, allowing them to experience the sensation of creativity, the expression of unconscious thoughts and phantasies, within the boundaries of a safe and holding environment. During this stage, the art offers the client the opportunity to have mirrored back to them, something of their internal reality that they may have been unable to see before. The therapeutic alliance provides the client with the opportunity to heal and rejoin previously 'split' object idealisations, allows for self object merger, leading towards a maturer and more realistic sense of self.

3. Theoretical Framework.

This research worked within the psychological and theoretical framework of object relations. This framework defines the process by which the child learns to individuate from its primary care giver leading to an understanding of self as separate from the parent. This process is more fully described by Mahler, Pine and Bergman (1975, p.63) below.

Phenomena of normal development can best be understood when elements of the process are (understood as being along two) developmental tracks. One is the track of individuation, the evolution of intrapsychic autonomy, perception, memory, cognition, reality testing; the other is the intrapsychic developmental track of separation that runs along differentiation, distancing, boundary formation, and disengagement from mother.

The researcher also acknowledges feminist ideologies which suggest that the patriarchy under which we live often sends conflicting messages to young females about food, body size and power, that may encourage them to enter into patterns of dieting that lead unwittingly, to a cycle of anorexic activity. As Orbach states, (Garner et al. 1985, p.90)

A woman tends to view her image in the mirror with a certain distance and the question of whether it (that is she) is acceptable (Berger 1972). The standard she applies reflects her internalisation of cultural values. . . Her body is a statement about her, the world and her position in the world. Since women live within prescribed boundaries, women's bodies become the vehicle for a whole range of expressions which have no other medium. . . In her attempts to conform or reject

contemporary ideals of femininity, she uses the weapon so often used against her. She speaks with her body.

4. Methodology.

4.1. Project Design.

The purpose of this research was to undertake a pilot study that identified if the art works of two groups of female teenage clients, (group A classified as anorexic and group B, classified as non anorexic) could be seen as significantly different within an art therapy application that uses an object relations framework.

Clients were first asked to take part in the Eating Attitudes Test (EAT 26) which validated inclusion or exclusion from each group. They then took part in three art therapy exercises, that used guided visualisation techniques and the development of a self portrait collage. Once the art therapy exercises were undertaken three 'blind reviewers' scored the work, using a series of questions that were developed using Elkisch's projective techniques as a means of organising the art works into the categories of enmeshed, isolated, or inter related.

This study utilised both qualitative and quantitative methods for data collection and employed a simple two group comparison approach for data evaluation.

Recent developments in the evaluation profession have led to an increase in the use of multiple methods, including combinations of qualitative and quantitative data. . . . Because qualitative and quantitative methods involve differing strengths and weaknesses, they constitute alternative, but not mutually exclusive, strategies for research (Patton, M. Q., 1990, p.11)

4.2 The Subjects.

GROUP A	GROUP B
Five clients presently taking part in EDU program. ¹	Five clients not taking part in EDU program.
Inclusion criteria	
<p>13 - 16 yrs Female. Metropolitan area based. Fulfil DSM IV anorexia criteria. Grade one nutritional functioning.² Not been in patient in a hospital - diagnosis AN.</p>	<p>13 - 16 yrs. Female. Metropolitan area based. Do not meet DSM IV AN criteria (based on EAT 26 test). No history of eating disorder requiring hospitalisation. Normal nutritional functioning.</p>
Exclusion criteria	
<p>Under 13 or over 16 yrs. Male. Country based. Meet DSM IV classification, but requiring nutritional resuscitation. Grade two or three nutritional functioning. Non group oriented (either seen as extremely solitary or display behaviour that would lead to ostracism. eg. sexual perversion, paranoid ideation, severe delinquency).</p>	<p>Under 13 or over 16 yrs. Male. Country based. Presently classified under DSM IV for AN. Grade one, two or three nutritional functioning. Non group oriented (as outlined in group A).</p>

¹ Five clients equals ten percent of the total number of anorexic clients that have taken part in the eating disorders program since it was established, in May 1996. It is also equal to the standard number of clients that take part in each group intake for the program.

² Grade one level of nutritional functioning is the equivalent of mild malnutrition, which equals less than the 5th percentile for age corrected weight. Grade two is moderate malnutrition, and grade three is severe malnutrition.

4.3 Project Materials.

4.3.1. EAT 26 - Eating Attitudes Test.

A 26 item self report measure designed to evaluate a range of attitudes and behaviours associated with anorexia nervosa. Each item is answered on a 6 point Likert scale, high total scores are indicative of symptoms, but not necessarily the diagnosis, of anorexia nervosa. (Allison, 1995, p. 355)

4.3.2. Elkinsch's projective techniques with children.

Four pairs of criteria that recognise and evaluate the drawings and paintings of children, to indicate the client's ego state, and possibly reveal fixations with in earlier stages of psycho sexual development. "Expressive movements reveal an element which one might call unconscious, instinctual, primitive, archaic, and which relates to a person's body feelings and body image." (Rabin & Haworth, 1960, p. 273)

4.3.3. Self portrait collages.

Through the use of images, colours, lines, shapes and words found in magazines, clients produce collages using the media as a way of making self portraits. Gray and Arnold (1994, p.2) state,

Working with 'self portrait' collages is an expressive and abstract way of introducing participants into an artistic process that can initially seem to be overwhelming. The self portraits are generally visually strong and give an interesting insight into the lives of young people.

4.3.4. Guided imagery visualisations.

Clients are invited to listen to a series of guided visualisations and then to respond to this stimuli by producing art works of their choice. Bloomgarten and Kaplan (1993, p. 210)

believe that guided visualisations have the primary goals of enhancing self esteem, improving interpersonal relating and increasing awareness of personal values.

4.3.5. Expendable art materials.

Coloured papers, pastels, chalks, magazines, scissors, glue, and coloured texta's.

4.4 Procedure.

4.4.1 subjects obtained.

Five female subjects (group A) aged between thirteen and sixteen, who were taking part in an eating disorders outpatient program, located at a local children's hospital, took part in three one hour group art therapy sessions. Subjects took part in these art therapy sessions as part of the usual practices of the E.D.U. out patients' program. The sessions are designed to encourage personal awareness through art making techniques.

The sessions were built in to the eating disorders program presently offered by the hospital and were run by an art therapist and supervising permanent member of the E.D.U. team. The Eating Disorders Unit is located within the psychiatric department of the children's hospital.

The E.D.U. gives each client access to an individual case manager, cognitive behavioural sessions, nutritionist programs, adolescent issues programs, recreation activities (and family therapy sessions, if the family is willing to participate).

Even though these sessions were built into the normal program that clients participate in, it was explained to the group of clients that these sessions, if agreed upon by them, would

also become the basis of a comparative study, as a way of gaining greater understanding into anorexia nervosa. (See appendix H and I)

Paralleling this process, five female clients (group B) who are deemed to be non anorexic, of similar age and from a similar demographic make up, took part in the above mentioned group art therapy activities. These clients were drawn from a local high school and were invited to take part in the art program by the school psychologist.

These clients were also informed of the purpose of the workshops prior to their commencement, (see appendix H and J) and with the support of the school and their parents, agreed to participate in the three workshops proposed. (see appendix K and L)

It should be noted that the proposed art therapy interventions were not developed as a response to the condition of anorexia, but were proposed because they work well with young people, whether classified as anorexic or not. In rationalising the approach of using visualisations with high functioning clients, Bloomgarten and Kaplan (1993, p. 201) state, "Our aim is to promote optimum mental health rather than to address psychopathology. We assume that the more mature the individual, the more resources that person will have to deal with life's problems - including mental illness." With this in mind, it was felt that those clients that make up group B still had much to gain by participating in a process that encouraged self awareness and ego strength, despite a linkage to the condition of anorexia nervosa.

These art therapy sessions took place in the school psychologists' group meeting room, on site at the school these students attend and clients had access to the school psychologist for additional therapy if required.

Although participating in the art therapy sessions at different locations, sessions for both groups participating in this research were conducted by the same art therapist and took place at similar times of the day. Sessions were replicated for each group, including providing materials and instructions in an identical fashion and in the questioning to follow in the discussion phase of the session.

Prior to the art therapy sessions, all clients undertook the Eating Attitudes Test (EAT 26) (Appendix B.) as set out in the Handbook of Assessment Methods for Eating Behaviours and Weight Related Problems (Allison, D. B. 1995, p. 355) Tests were then scored by a psychologist from the Eating Disorders Unit to identify client suitability to take part in either group for art therapy data collection.

"The EAT has seven factors: food preoccupation, body image for thinness, vomiting and laxative abuse, dieting, slow eating, clandestine eating, and perceived social pressure to gain weight." (Allison, D.B. 1995, p 357). The EAT 26 is a test of great sensitivity, which produces a high level of true positives as compared to false positives. For this reason, "the alpha coefficient for the total score of EAT is found to be high." (Allison , D.B. 1995, p.357)

Taking into consideration standard deviations, subjects had to score over 20 in the EAT 26 test to be eligible to take part in group A (anorexic subjects) or less than 20 to be eligible to be included in group B (non anorexic subjects).

4.4.2 Sessions conducted.

Each art therapy session was of one hour duration. Each week the art therapist facilitated an art therapy exercise and clients were invited to respond to the exercise using the materials provided.

After each group of clients had completed the weekly task, they were invited to discuss the works they produced. If clients did not wish to discuss their works with the rest of the group, they were given the freedom not to do so.

Session One. Beginning Phase.

According to Fleming (1989, p.289) the purpose of the beginning stage of therapy is to combine the use of art therapy topics and materials with non intrusive discussion, so that a safe and nurturing environment is produced. Once given permission to protect and care, Fleming believes that the client is able to acknowledge feeling threatened and needy, yet special. Drawing and collage materials support and reflect cognitive strengths.

For this study, clients were welcomed to the group and the purpose of the study was explained to them. The duration of the workshops was reiterated as was the number of workshops that they were to participate in. Clients were also be reminded of their rights during the process and were asked to sign art therapy release forms prior to beginning the sessions. (Appendix H)

Art therapy instruction. "Using pictures, colours, words and images found in magazines that you are in some way drawn to, make a collage on an A3 sized piece of paper. You must fill in the whole page, leaving no sign of the white paper on which the images are to be placed. If you cannot find enough images in the magazines that you want to include you may fill in the additional spaces using the pastels and textas provided. You will have forty minutes to complete the task."

At the completion of the forty minutes, clients were invited to place their art works on a wall, side by side and then to take a few steps back from the works, creating distance between the art and their makers.

Post drawing instruction. "Today, we will not be asking you to discuss the works you have made, but invite you instead to take this opportunity to let yourself be surprised and possibly delighted at the art works you have made. You might like to make a mental note of which image on the page you think stands out the most and which one do you feel you need to keep returning to. You might ask yourselves which one surprises you that it has appeared and which one do you now wish you could remove? You might also like to look at the work that others have made, and again, just for yourself note which ones you are drawn to the most. Which one is most like yours and which one is least like yours? When you have finished viewing the works, please take your art work down from the wall and place your name and date on the back of the page. Once this has been done, you are free to leave for the day."

Session Two. Transitional phase.

Clients were welcomed to the session and invited to take a seat. Once seated, the exercise began.

Art therapy instruction. "Today we are going to take part in a visualisation. If you feel comfortable enough to close your eyes please do so. If you do not wish to do this, look down at your lap so that you are not making eye contact with others in the room. Take a deep breath in, and allow the breath to be released slowly." The rose bush visualisation (Allen, J. B., 1989, p.223) is then read out. (see appendix C)

In explaining the significance of this particular visualisation and it's use with clients, Allen (1989, p.82) explains that "The purpose (is) to determine whether the pictures and words of the coping children reflect inner health, whereas those of non-coping children signify inner turmoil". This is achieved through the comparing of the visual imagery (i.e., the

drawings) and the metaphorical statements (i.e., the words used to describe the pictures) of coping and non coping children.

Art therapy instruction (cont): "When you feel ready return to this room and open your eyes. Take a piece of paper from the centre of the table and draw the rose bush that you visualised in your mind. You will have twenty minutes to complete this task."

Post drawing instruction:

Each client was invited to talk to their picture and at the completion of the session was again asked to place their name on the back of their pages and invited to title their work if they wanted to.

Session Three. Closing phase.

Clients were again welcomed to the session and invited to take a seat. They were reminded that today was the last session for this study, and that if they felt they needed to discuss the sessions further with the art therapist, an additional time could be made for this purpose.

Art therapy instruction "Today we are again going to take part in a visualisation. If you feel comfortable enough to close your eyes please do so. If you do not wish to do this, look down at your lap so that you are not making eye contact with others in the room. Take a deep breath in, and allow the breath to be released slowly." The existential therapy visualisation (Bloomgarten and Kaplan, 1993, p. 203) is then read out. (See appendix D)

Visualisation was our method of choice because of the powerful results imaging has reportedly produced in recent years (Korn and Johnson, 1983). Epstein (1989) states that research has not examined the phenomenon of healing through imagery in a methodical way, but drawing upon clinical experience, imagery has been found

to reinforce healing of both mind and body. (Bloomgarten and Kaplan, 1993, p. 203)

Art therapy instruction (cont) "When you feel ready, return to this room and open your eyes. Take a piece of paper from the centre of the table and draw what you saw, or what this visualisation has made you think about. You will have twenty minutes to complete this task."

Post drawing instruction: Each client was invited to talk to their picture and at the completion of the session was again asked to place their name and the date on the back of their pages and was thanked for their participation.

After the three week program of art therapy interventions was completed, the art therapist coded the art works, so that the owner of each art work was known only to the art therapist. An independent art therapist and two psychologists from the eating disorders unit program, 'blind reviewers', took part in an inter rater reliability training session, as preparation for scoring the work. The inter rater training consisted of three segments. Segment one - education on using the Elkisch's projective techniques with children document; segment two - a thirty minute supervised scoring of trial material, and segment three - a thirty minute blind inter rater reliability module. On completion of this training component, the art therapist and psychologists undertook a 'blind review' of the art works produced by the two client groups, using the questions devised to fit within the Elkisch's projective techniques formula. This was used as a way of identifying which works they believed to be indicative of clients' ego boundary cognition within the framework of object relations.

The following guides were used for the scoring of the art works.

Session One: art task : collage.

• Complexity/simplicity.

1. Number of images used

o Less than 20

o More than 20

2. Relative amounts of cut out pictures to drawing

o mostly all cut outs

o cut outs and significant spaces

o mix of drawing and cut outs

• Expansion/compression.

3. Variety of images/themes

o little variety (fixation with type of image or theme) <5

o good variety >5

• Integration/disintegration.

4. Use of space (looking only at cut outs)

o disparate (space in final picture)

o complete use of space

o limited/clustered use of space

• Rhythm/rule.

5. Dominant feel of work

o negative (displeasing, uninviting or uncomfortable)

o positive (relaxed or confident)

o limited or incomplete

6. Client assessment.

o anorexic

o non anorexic

Session two: art task: rosebush visualisation

• Complexity/simplicity.

1. About the rosebush or rose

well constructed

poorly constructed

• Expansion/compression.

2. Environment the rosebush is placed in

overwhelming environment

supportive environment

little support or unfriendly environment

• Integration/disintegration.

3. Rose in relation to environment

image encapsulated (surrounded) or entrapped (limited movement)

image overwhelmed or entangled (touching) with another image

none of the above

4. Use of space

centred spacial quality

disorganised use of space

limited use of space

• Rhythm/rule.

5. Feel of work

negative (displeasing or uninviting)

positive (relaxed or confident)

limited or incomplete

6. Client assessment anorexic not anorexic

Session Three : art task: existential visualisation

• Complexity/simplicity.

1. Theme of art work

- o self (inward) focused art work
- o global (outward) focussed artwork
- o none of the above

• Expansion/compression.

2. Variety of images and words

- o little variety or obscure theme <5
- o good variety of images or clarity of themes >5

• Integration/disintegration.

3. Use of space

- o disparate
- o balanced use of space
- o clustered use of space

• Rhythm/rule.

4. Feel of work

- o negative (confusing or non involving)
- o positive (relaxed or confident)
- o separateness

5. Client assessment. o anorexic o non anorexic

4.5 Data Analysis.

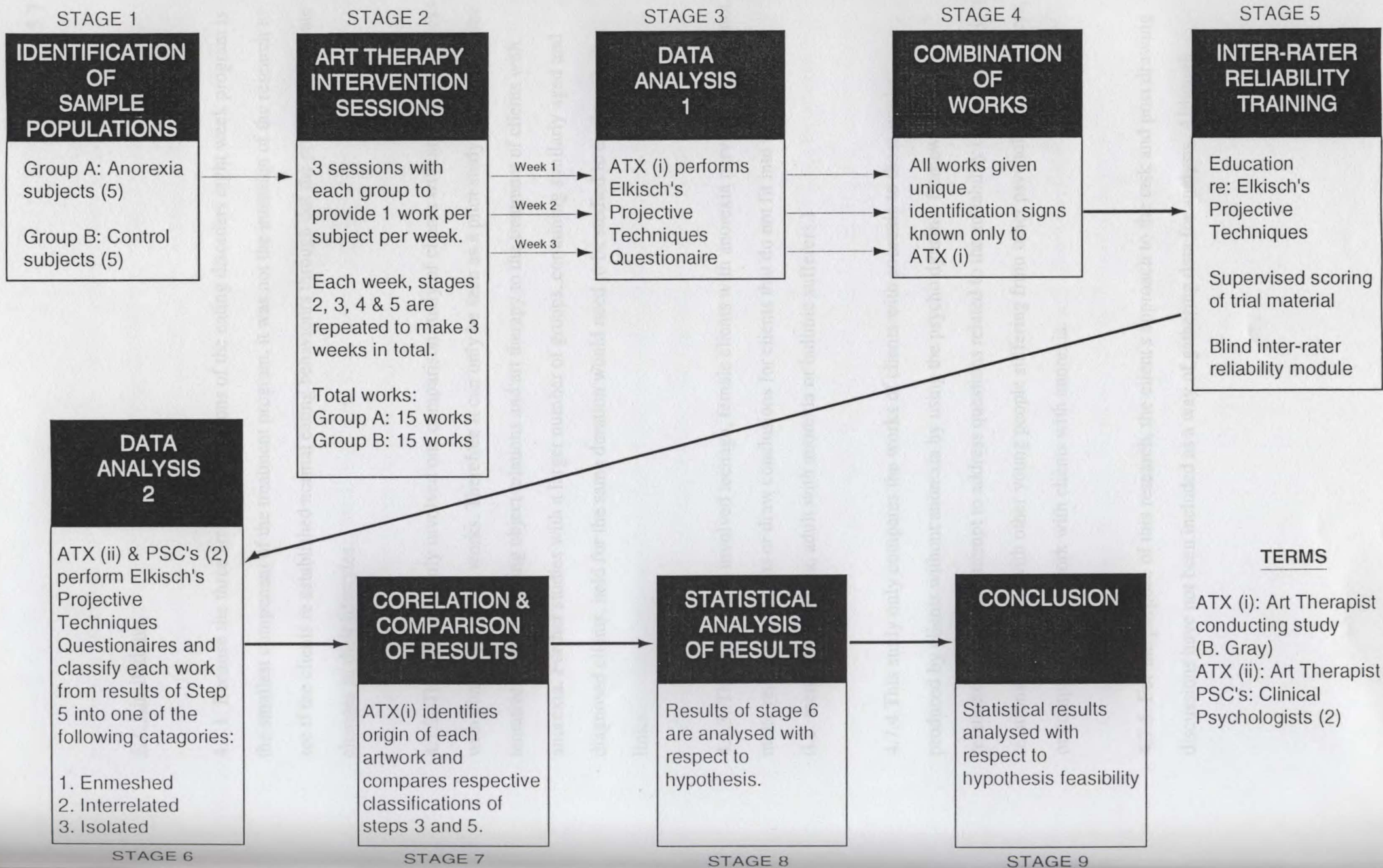
Finally analysis was made to test the original hypothesis. Initial analysis ascertained any differences between controls and the subjects with anorexia. Treating anorexia caseness as a nominal (0,1) variable, significant differences were sought between sociodemographic factors between the two groups using Chi square analysis for categorical variables and independent samples T Test for continuous variables. Analysis of the major hypotheses utilised a similar strategy - anorexia caseness was the independent variable, dependent variables were those art therapy measures detailed in the project materials section. It was anticipated that univariate and bivariate analysis but not multivariate analysis would be possible with the project's sample size.

Data generated by this research was entered in the statistical package for Social Sciences (SPSS) data editor, subsequent analysis will also utilise SPSS version 7.0. Statistical and analytical support was provided through the Departments of Paediatrics and Psychiatry at the participating hospital

The validity and reliability of qualitative data depend to a great extent on the methodological skill, sensitivity, and integrity of the researcher. Systematic and rigorous observation involves far more than just being present and looking around. (Patton, 1990, p.11)

On completion of the project, all art works were returned to their makers and data was fed back to the Eating Disorders Unit at Princes Margaret Hospital, with the intention of establishing further collaboration for the development of therapeutic programs that encourage clients to create more inter related boundary delineations, as defined within the object relations framework.

PROJECT METHODOLOGY FLOWCHART



4.7. Limitations.

4.7.1. Because the three art therapy sessions of the eating disorders eight week program is the smallest component of the treatment program, it was not the intention of the research to see if the clients re established normal eating behaviours through out the program or initiate changes in their lifestyles.

4.7.2. This research only involved one comparison study of clients with anorexia art works with control group art works. Therefore it can only be seen as a pilot study leading to some tentative findings linking object relations and art therapy to the treatment of clients with anorexia. Further studies with a larger number of groups, containing similarly aged and diagnosed clients, held for the same duration would need to be studied to explore further links.

4.7.3. This study only involved teenage, female clients with anorexia nervosa and does not make recommendations or draw conclusions for clients that do not fit into this category. (i.e. men with anorexia, adult with anorexia or bulimic sufferers.)

4.7.4 This study only compares the works of clients with anorexia to those works produced by clients without anorexia by using the psycho dynamic framework of object relations. It does not attempt to address questions related to the suitability of using an object relations framework with other young people suffering from other psychological disorders, or compare their art work with clients with anorexia.

4.7.5. For the purpose of this research, the client's approach to the task and post drawing discussions have not been included as a way of gathering data for analysis. Although

important to the clients and their therapeutic process, reviewers were asked to view the artworks independently and to look for distinguishable differences in picture construction between the two client groups, without having access to this additional information.

5. Ethical Considerations.

Given that the clients being identified for the study are still legally minors, special consideration was given to ensure that they understood their rights within the process undertaken. Before the first session began, clients were re-informed of their rights and asked to complete consent forms that they signed and dated. These forms were witnessed by an additional adult, not the art therapist. (See appendix H)

The wording of the release form was taken from the form that art therapists use when entering clinical placements as part of their training at Edith Cowan University. It was also explained to clients that they may withdraw the right to use their work for this study at any time they feel is necessary.

As well as the above mentioned client release forms, appendix F indicates the ethical considerations that needed to be noted for clients in group A, and Hospital support for the project. For those clients that make up group B, a letter and consent form explaining the project and requiring a parental signature, was sent to their parents requesting their permission for involvement, prior to their child's involvement.

Once parental support for the project was acquired, these clients were also asked to fill in art therapy release forms, releasing the art work for the final analysis and written document. Again these forms required a witness signature, not that of the art therapist.

6. Budget.

Expenditure.

Art Paper	\$20.00
Pastels	\$20.00
Chalks	\$20.00
Glue	\$10.00
Film and Developing	\$100.00
Scissors	\$20.00
Texta's	\$10.00
Printing and Binding Costs	\$200.00
Proof Reading	\$200.00
Computer Hire	\$180.00
Telephone & Internet connections	\$50.00
Petrol Expenses (83 km's @ 60c/km)	\$50.00
Office Space and Utilities	\$200.00
 Total Expenditure;	 \$1,080.00

7. Discussion

For the purpose of this discussion, data analysis has been organised into five different categories, and although not exhaustive, they represent the five most significant areas that warrant follow up when discussing teenage anorexia and art therapy in future studies.

It is also important to note, that for this discussion, the scores for enmeshed with isolated have been combined to represent the category of 'not interrelated' and compared with the scores given to client art work that represent an interrelated approach to the task. It was anticipated that clients with anorexia would fit into the category of 'not interrelated', with the possibility of further classifying the works into either enmeshed or isolated, and that clients without anorexia (controls) would create works that was interrelated.

The reason for combining the two possible scores of enmeshed and isolated into the one category of not interrelated, was because, although reviewers were significantly successful in matching correctly clients with their anticipated classifications, there was insufficient data to establish a difference in the art works of clients with anorexia into the categories of enmeshed and isolated.

The categories that I have highlighted in this study can be summarised through the answering of the following questions noted below.

7.1. Reviewer inter rater reliability.

7.1.1 With reference to the reviewers, how often were clients coded in a similar fashion successfully?

7.1.2. Did any one reviewer consistently score differently or incorrectly to the other reviewers?

7.1.3 Did a bias become apparent in the categorising of anorexia amongst clients?

7.2. Elkisch's projective techniques.

7.2.1 With regards to Elkisch's projective techniques, how many of the rules proved to be successful when correctly categorising client art work?

7.2.2 Which rules proved to be most successful in correctly categorising clients?

7.3. Specificity and sensitivity.

7.3.1 How often did the classification given by reviewers match the true classification (that is anorexic or non anorexic) of the clients?

7.3.2. With reference to those clients that were classified differently to their true classification, how often was that client incorrectly scored over the three weeks and by how many reviewers?

7.4. Validity and effectiveness of art exercises chosen.

7.4.1 How successful were the art therapy exercises in providing information about client's ego boundary cognition's?

7.4.2 Was any one art exercise more successful in identifying clients ego boundary cognition than the others?

7.5. Significance of analysing the data over the three week time span.

9.5.1 Did any additional information present itself as significant when viewing client art work over the three week period of art therapy?

Analysis within these categories and discussion follow.

7.1. Reviewer inter rater reliability.

Reviewers' scores of client art works varied from complete agreement and correct classification (all three reviewers successfully matching the client with their anorectic classification) through to no agreement on client scoring (reviewers having different classifications for clients, based on different scoring responses).

Although there were variances in the scoring of clients amongst reviewers, no one reviewer was significantly more successful or unsuccessful in correctly coding clients and their artworks. The variances could reflect the diversity of reviewers professional training or implicate the effectiveness in inter rater reliability training of the researcher in recognising these differences.

A kappa analysis of inter rater reliability was not possible given the small sample size and cell number for a 2x2 contingency table.

When using the rules established under the guidelines of Elkisch's projective techniques to provide a classification of clients over the three week period, 49% of clients were classified as anorexic, whereas 51% of clients were classified as non anorexic. This would suggest that no apparent bias presented itself in the categorising of anorexia amongst the total client population.

7.2. Elkisch's projective techniques.

Given that there were five clients within each classification, each being scored by three reviewers, combined scores meant that there were fifteen potential results under consideration for the answering of this question.

Week one: task - collage

For the rule of complexity versus simplicity, all clients with anorexia created work that contained less than twenty images and none of their artworks consisted of more than 70% cut outs. The exact opposite was the case for control clients, with once again all reviewers agreeing on the results. Within this framework, it would then be appropriate to suggest that there was a significant difference in the work produced. Clients with anorexia produced works that lacked detail or with impoverished differentiation, whereas the controls created works that were complete or detailed in their finality.

For the rule of expansion versus compression, reviewers were successful 80% of the time in correctly identifying clients with anorexia and were correct 73% of the time in identifying control clients. Therefore overall it would be appropriate to suggest that clients with anorexia tended to make works that created a feeling of meticulous smallness or the experience of being closed in whereas the controls created works that reflected a sense of spaciousness in the themes represented in the final art works.

For the rule of integration versus disintegration, reviewers were successful 93% of the time in identifying clients with anorexia and were correct 87% of the time in identifying client controls. This would suggest that clients with anorexia consistently created art works with either a disparate or clustered use of space, creating artworks where a sense of oneness is not evoked. In contrast the control group created artworks where the space was completely filled, suggesting a feeling of the whole with things in place, thus demonstrating an ability to relate, combine and organise.

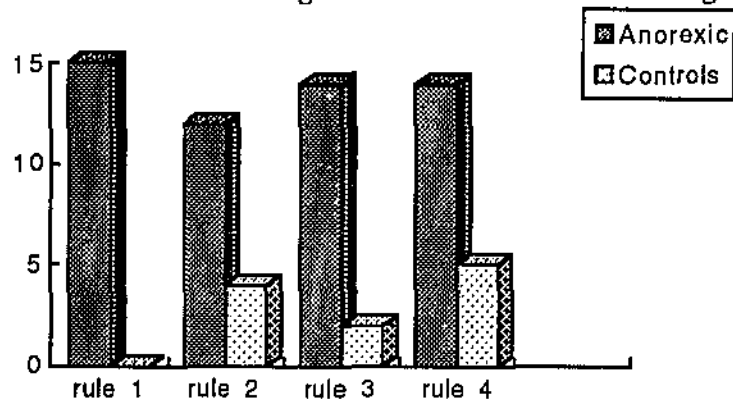
For the rule of rhythm versus rule, reviewers agreed 93% of the time when classifying clients with anorexia, and 66% of the time when classifying controls. This would suggest that clients with anorexia created works that had a negative feel to them, that is either a

displeasing, uninviting or incomplete feel, whereas the controls were more likely to create works that had a positive or relaxed feel to the art work.

In terms of identifying the significance of viewing these works within Elkisch's framework it could be suggested that the rules of complexity versus simplicity was the most successful in distinguishing between the two client groups, whereas the rule of rhythm versus rule was the most unsuccessful. It can also be inferred by these results that within the framework of this art exercise, it was easier for these reviewers to correctly classify clients with anorexia than it was to classify controls, possibly suggesting that all clients created artworks with overall themes leading towards a preoccupation with self image or low self esteem.

Graph 1.

Reviewer classification (combined) in relation to Elkisch's projective hypotheses in ascertaining anorexic caseness.- collage.



Rule 1: complexity v's simplicity. Rule 2: expansion v's compression.

Rule 3: Integration v's disintegration. Rule 4: Rhythm v's Rule.

Week two - task rosebush visualisation.

With reference to the rule of complexity versus simplicity, there appears to be little difference between client groups ability to construct adequately desired rosebushes, with overall two thirds of all clients scoring an interrelated approach from reviewers, regardless of client classification. Just over 53% of clients with anorexia created poorly constructed rosebushes, whereas 86% of control clients created well constructed rosebushes. This would suggest that this rule had little effect on reviewers ability to differentiate between the two client groups.

In analysing the rule of expansion versus compression, clients in both groups scored a 73% in their anticipated responses. That is, 73% of all clients with anorexia produced rosebushes that were placed in either overwhelming environments or environments that provided little support, and for 73% of the control group, rosebushes were placed in supportive environments.

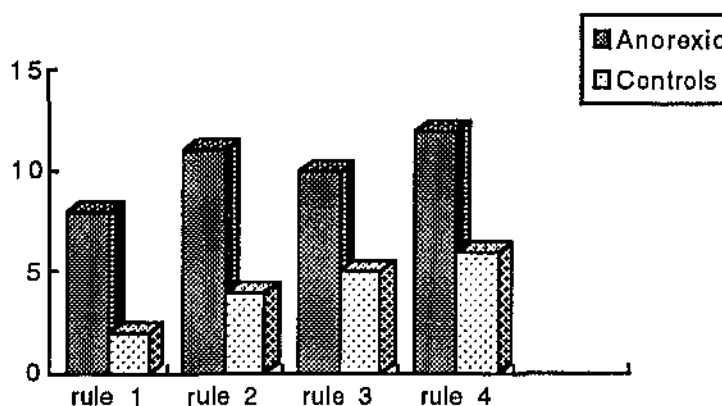
With reference to the rule of integration versus disintegration, 66% of all clients with anorexia produced images that were encapsulated or entangled with another image, but were still able to produce works that were centred in their spacial quality. Similarly, the control group produced rosebushes that were not encapsulated or entangled with another image in 66% of all occasions and were also able to centre their works in 87% of all occasions. This would suggest that the clients' ability to centre or not centre their work was not significant in this research or indicative of the clients' ego states. However where they placed their central image in relation to other images placed on the page did prove to be highly significant in describing their ability to relate to the outside world and to successfully organise or make sense of these relationships.

Finally in analysing the results of rhythm versus rule, reviewers suggest that in 80% of cases clients with anorexia produced works that had an overall negative feel to them, where the works were either uninviting, displeasing, limited or incomplete. Reviewers also noted that in 60% of all cases, control clients created works that had a positive feel, suggesting a relaxed or confident feel to the final art work.

In summing up, it would appear that the most value to be gained from undertaking this exercise with clients with anorexia is related to the rules of expansion versus compression and integration versus disintegration. Although these rules did not help to clearly define information related to the actual rosebush's created on the page, what they do is highlight the importance of the rosebushes relationship to other elements placed on the page, possibly providing information for the therapist about the clients relationships with significant others and the outside world.

Graph 2.

Reviewer classification (combined) in relation to Elkisch's projective hypotheses in ascertaining anorexic caseness. - rosebush visualisation.



Rule 1: complexity v's simplicity. Rule 2: expansion v's compression.

Rule 3: Integration v's disintegration. Rule 4: Rhythm v's Rule.

Week three: task - existential visualisation.

With reference to the rule of complexity versus simplicity, reviewers agreed that in 93% of all cases control clients produced work that had an outward focussed or global theme in the artwork, whereas in 73% of all cases of clients with anorexia produced work that had an inward or self focussed theme or a theme that was unable to be distinguished. Using Elkisch's rule to interpret this would suggest that the lack of detail in the drawings created by clients with anorexia suggests regression or fixation with an issue or in an earlier stage of development.

When analysing the rule of expansion versus compression, all reviewers were in agreement that the clients with anorexia created works with little variety or an obscure theme, whereas the controls created artworks with a large variety of images or clarity of themes in 66% of all cases.

For the rule of integration versus disintegration, reviewers were in agreement that in 80% of all instances, clients with anorexia produced works where there was a disparate or clustered use of space, whereas the controls produced works that had a balanced use of space on all occasions. This would suggest that the controls were better able to produce works that, demonstrated the ability to relate, organise and combine, whereas the anorexic clients produced unrelated or disconnected works, where a sense of oneness was not evoked.

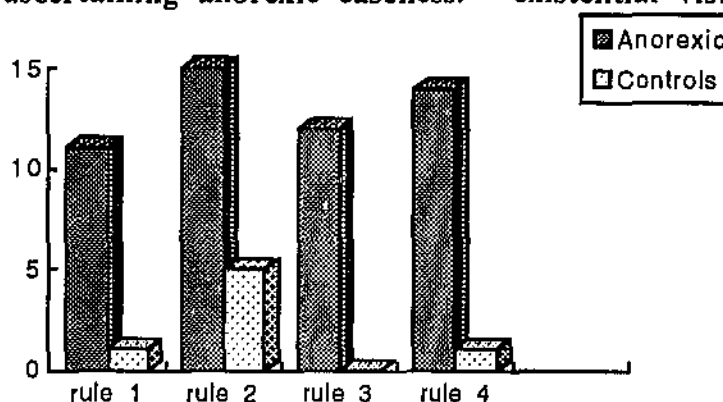
Finally for the rule of rhythm versus rule, both client groups scored 93% of the time in their anticipated category, where clients with anorexia produced art works that had a

negative feel to them, whereas the controls produced art with an overall positive feel, producing relaxed or confident art works.

In conclusion, all rules appeared to be successful in correctly identifying clients with anorexia and control clients. Overall clients with anorexia produced works that appeared to be inward focussed with little clarity of theme and disparate use of space, leading to the production of art works that had a negative or confusing feel to them. Clients in the control group tended to produce works that were of the exact opposite - that is art works that appeared to be outward focussed, with a good variety of themes and a balanced use of space.

Graph 3.

Reviewer classification (combined) in relation to Elkisch's projective hypotheses in ascertaining anorexic caseness. - existential visualisation.



Rule 1: complexity v's simplicity. Rule 2: expansion v's compression.

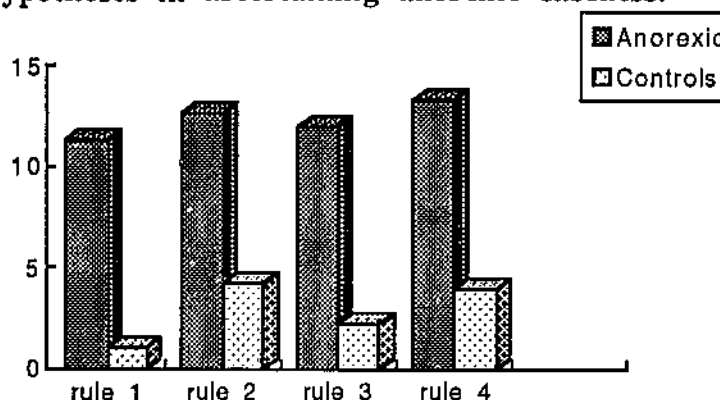
Rule 3: Integration v's disintegration. Rule 4: Rhythm v's Rule.

7.2. Summary.

In summarising the above information, when viewing anorexia nervosa within the rules established under Elkisch's projective technique's, it would appear that rule four, the projected rule of rhythm versus rule was most effective in distinguishing the art works of clients with anorexia correctly and rule one, which defines complexity versus simplicity was most effective in the correct projected classification of controls. This would suggest that overall, clients with anorexia tended to make art works that had a negative feel to them, suggesting a tight, spasmodic approach to the work, often done mechanically, whereas the controls tended to create works that appeared to be complete or detailed, given the art therapy instruction offered.

Graph 4.

Reviewer classification (mean) in relation to Elkisch's projective hypotheses in ascertaining anorexic caseness.



Rule 1: complexity v's simplicity. Rule 2: expansion v's compression.

Rule 3: Integration v's disintegration. Rule 4: Rhythm v's Rule.

7.3 Specificity and sensitivity.

Validity of the measure of art work to identify individuals with anorexia includes the measure of sensitivity and specificity. The measure of sensitivity is equal to the ability of the measure to predict the disease when it is present ($a/a+c$), and the measure of specificity is equal to the ability of the measure to predict the absence of the disease when it is absent ($d/b+d$). Table 1 below shows the method used for data analysis within this context.

Table 1

	Has An.	Doesn't have An.	
Test positive	a	b	a+b= positive predictive value
Test negative	c	d	c+d= negative predictive value
	a+c= sensitivity	b+d= specificity	

Table 2 presents a summary of validity data indicating the results for each reviewer, and Table 3 presents a summary of validity data, when reviewers results are combined and averaged (mean).

Table 2.

	sensitivity			specificity		
	1	2	3	1	2	3
collage	80%	60%	80%	100%	100%	60%
rose	100%	80%	80%	80%	60%	60%
existential	80%	80%	80%	100%	100%	60%
average	87%	67%	80%	93%	87%	60%

Table 3.

Mean.	sensitivity	specificity
collage	73%	87%
rose	87%	67%
existential	80%	87%

When comparing reviewers overall classifications with clients true classifications, regardless of the rules established under Elkisch's projective techniques, there was an 80% success rate in correctly diagnosing both anorexia and non anorexia.

Reviewers had the most difficulty in correctly scoring clients during the rosebush visualisation and the most success matching under the existential visualisation. This could be because one client known to be non anorexic was consistently scored by reviewers as anorexic based on her artwork during this week's exercise. Apart from this one client, scoring and its effectiveness was similar over the three art exercises.

With reference to the clients with anorexia, no one client was consistently misclassified over the three week period or by any one reviewer. One client from the control group was classified as anorexic by all reviewers in week two of the process and by reviewer three on each occasion over the three week period.

Variances in anticipated client classification could relate to the clients' state of mind each week, rather than being dependent on the condition of anorexia, and would indicate the importance of viewing client work over a period of time to gain insight, rather than using a one off art therapy exercise.

7.3. Summary.

A summary of the above mentioned results would suggest that the artworks of clients with anorexia could be seen as clearly different in construction and content from the art works of clients without anorexia, when Elkisch's projective techniques are used as the measure for this condition. This result would warrant further investigation with regards to their correct use and implementation when working with teenage clients with anorexia in future studies.

7.4. The significance of the art exercises chosen.

Week one: task - collage.

The most striking observation to be made with regards to the medium chosen and the clients' approach to the task, was that clients with anorexia had a great deal of difficulty in finding source material from the magazines that they felt comfortable to put in their final art works. Generally speaking, clients with anorexia were unable to completely fill the page, even though this aim was clearly part of the instruction for the exercise. The results of their efforts are the production of works that appear to have used the space poorly, with either a disparate or clustered spacial quality. They consistently produced works which displayed a fixation with a theme or image, producing artworks that had a negative feel to them, leaving the reviewers feeling displeased, uninvited or uncomfortable.

The inability or unwillingness to completely fill the page as requested, may be indicative of the clients' poorly defined ego boundaries, perhaps reflecting their need for personally defined space from others or the unwillingness or inability to completely fill the space that their reality offers to them. With reference to the condition of anorexia, this may be linked with their need to diet, by physically taking up less space they create for themselves a new set of boundaries, both physical and mental, that provide few points of connection with the outside world.

Examples of artworks produced - week one collage.

Example 1. Client with anorexia



Example 2. Client with anorexia



Example 3. Control client



Example 4. Control client



The obsession with theme or a limited number of themes would suggest that the clients are again having difficulty in relating to the outside world, needing more importantly to reflect more deeply on their own internal world. Preoccupied as they are with an intolerable fear of losing control, of being consumed or invaded by another person, their need is to sort through and make meaning of the small number of themes that occupy such a large part of their everyday world.

This need to explore and redefine their connection with other objects and symbols should not be interpreted as being a fault or limitation but rather interpreted as a positive way in which the client with anorexia re-engages with themselves and their relationship to internal and external objects. The capacity to think reflectively indicates a state of relatedness to the object, whereas the client with anorexia is still distracted by an inability to sort i.e. differentiate phantasy from reality.

Week two: task - rosebush visualisation.

In recognising the projection of the client onto the rosebush in these images, it was interesting to note that on very few occasions did the clients have difficulty in centring their rosebushes, nor did the construction of the rosebush clearly help to differentiate between clients with or without anorexia. That is to say that clients from both groups were able to produce rosebushes that were either large or small, well defined or poorly defined. This could be suggesting that the significance of asking clients to represent themselves within the image of a rosebush will give the therapist some information about how the client is feeling about themselves on that given day.

Where this exercise did become significant in the distinguishing of clients with anorexia from control clients was in the reading of the environment in which the clients placed their rosebushes. Just as the condition of anorexia tells us something about *how* the client is

choosing to cope with what is of concern to them in their lives right now, these drawings may provide us with some indication of *what* it is that they are coping with. This could be demonstrated through repeated images of roses engulfed, intertwined or unable to be seen clearly in the page by clients with anorexia, as compared to control clients who drew

Examples of artworks produced - week two rose bush visualisation.

Example 1. Client with anorexia



Example 2. Client with anorexia



Example 3. Control client



Example 4. Control client



rosebushes in supportive environments, often with other living things surrounding or caring for them.

In relation to their ego boundary cognition, this again could be suggesting that clients with anorexia are experiencing difficulty in seeing themselves as both separate from other symbols on the page and still related to these symbols in an appropriate or meaningful way.

Week three: task - existential visualisation.

The most significant difference in the resulting art works produced by the clients with anorexia, was their inability to produce art works that appeared to relate to the generic theme of the visualisation. Control clients tended to produce art works that thematically expressed their dreams for the world in which we live, often expressing a variety of wishes represented with great clarity and spacially centred. These art works represented their ability to project into the future, to think globally and with both a self and others focus. In contrast, anorectic clients had difficulty in producing works that talked about their futures and often created works with confusing or obscure themes. They had difficulty again in placement of symbols on the page producing artworks with which displayed either a disparate or clustered use of space.

In relation to what these findings may be telling us about their ego boundary cognition, their approach and resulting art works appear to depict little connection with the outside (external) world or with little ability to focus or project into the future suggesting a sense of isolation, obsession with an earlier stage of development or fixation with an unresolved issue.

Examples of artworks produced - week three existential visualisation.

Example 1. Client with anorexia



Example 2. Client with anorexia



Example 3. Control client



Example 4. Control client



Summary.

All exercises appeared to offer concrete evidence in the identifying of client's ego boundary cognition, when viewed within an object relations framework. More importantly, when viewed cumulatively, the information proved to be valuable when analysing client art work produced over a significant period of time. Metaphorically speaking, the progression of art exercises chosen represented the clients relationship to themselves, significant others and finally the world at large. The value in reading the work thematically was gained through the identifying of repeated themes, symbols and approaches to the task, all of which helped to reinforce the reviewers' interpretations of clients ego boundary cognitions.

7.5. Significance of analysing the data over the three week time span.

Although not within the parameters of the study for reviewers, it was important to analyse client art work over the time span of the project as a way of establishing whether initial classifications held true for clients or whether the art works produced were more reflective of issues related to the clients state of mind on any one given day.

What became apparent through this analysis was the significance of a symbol, colour or compositional quality for all clients with anorexia, that repeated itself over the three week period. These qualities reappeared over the three weeks, regardless of the theme of the weekly exercise, or the appropriateness of them in the artwork, given its context. This was not the case for clients in the control group.

This could suggest the significance of this symbol or colour to act as a transitional object, for the client during the process. Whilst the potential for the pictorial symbol to replace eating as the client's transitional object was not explored in this study, it is intended that the idea could be explored in greater detail in a future study.

Clients in the control group rarely repeated symbols or one dominant colour and appeared to find it much easier to concentrate and respond to the content of the art exercise offered each week. Over the three weeks, control clients, whilst varying the markings on the page, appeared to have no difficulty in completely filling the page or in presenting a variety of themes that responded to the weekly art therapy instruction.

This could suggest a lack of preoccupation with any unresolved issues, indicating healthy self esteem and an interrelated approach to ego boundaries. Inherent in this argument is the understanding that when viewing works within the framework of object relations, control clients appeared able to respond to the theme of the task proposed in a way that suggested an ability to respond to outside stimuli, free of personal preoccupation. The complete use of space (that included images representational of both self and others) would also be indicative of an acceptance and understanding of the boundaries and points of connection that we all establish and internalise as part of the individuation process.

8. Conclusion.

Although the data was unable to distinguish clients clearly into the categories of interrelated, enmeshed and isolated, it was able to produce highly significant results when distinguishing clients with anorexia into the combined categories of enmeshed and isolated (to represent a non inter related approach to their ego boundary cognitions), from the control group who created art works that suggest interrelated ego boundary cognitions.

Findings from this study would suggest that using art therapy as the measure for determining anorexia amongst clients proved to have an 80% success rate in the areas of both specificity and sensitivity.

Table 4. Summary Data.

Mean	Sensitivity	Specificity
Collage	73%	87%
Rose	87%	67%
Existential	80%	87%
Average	80%	80%

Using art therapy as the means for clients to explore their ego boundary cognitions provided both the client and the therapist with information on how the clients define themselves and their ability to relate to others and the outside environment. The significance of this statement lies in the ability to use art therapy as a means for non verbal communication with a client group that predominantly has difficulty in naming their feelings and often feel threatened by the use of verbal therapy for treatment of their condition.

In line with reviewed literature, this would correspond to the understanding that when viewed within an object relations framework, anorexia is a condition that has its roots in a pre verbal stage of development. This supports the belief that a clinical response that includes an art therapy approach that is predominantly non verbal approach may be the most appropriate modality for this client group.

With reference to the difficulties in distinguishing clients with anorexia into the sub categories of enmeshed and isolated, it is suggested that a more in depth study would need to be undertaken to establish why these results could not be produced, to identify what might be contributing and confounding factors.

Possible causes warranting further investigation could be in the design of the research methodology, that is in the appropriateness of questions used in the interpreting of Elksich's projective techniques or the depth of training for the raters to ensure parallel intentionality before they were asked to perform their rating task in inter rater reliability training.

Also warranting scrutiny is whether the appropriate theoretical framework was identified, questioning whether it is possible to identify or categorise clients into these interpretations of ego boundary cognition's, when using art therapy as the measure for the experiment.

What is still unexplored and was beyond the perimeters of this study was how the art works of clients with anorexia compared with other clients presently utilising the facilities in the psychiatric department of the hospital used for this study. This could be done by expanding the number of groups involved in the research model or a particular known population could be included to rule out a factor that might be typical among hospitalised clients which would be different from non hospitalised clients.

This analysis might have contributed additional information about the differences in picture construction and theme by clients with anorexia from clients without anorexia and from other clients suffering from different psychiatric conditions. Such a study might identify unique art therapy responses of anorexic's that could have valuable application to the use of art in the assessment of different patient populations.

Given that review of this experiment does not include discussion of art works made, nor does it annotate client approach to the art tasks, the experiment was still able to clearly indicate differences between the artworks of clients with anorexia and that of control clients.

The most significant differences to emerge were: use of space, ability to create art works with a positive or inviting feel, ability to respond to task, ability to include a variety of themes in picture construction and the significance of the environment in which the central image is placed.

The outcomes of this study suggest that art therapy may have a significant role to play in the identifying of anorexia amongst potential clients and could be used successfully as an adjunct to present assessment procedures used, because of its ability to produce different yet significant material not able to be gleaned through current procedures.

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APPENDICES.

Appendix A - Eating Disorders Unit in Western Australia.

The Eating Disorders Unit (E.D.U.) was established in May 1996. Funded under the Medibank Incentive Program, It was established as a response to staff concerns that prior attempts at treating clients with anorexia in the hospital setting were proving to be extremely costly both financially and resource wise. They appeared to be having little affect on a growing population of sufferers.

Prior to the program being established, once clients were assessed and diagnosed as being anorexic, they were hospitalised, for an average stay of six months each, until it was felt that the client was capable of returning home. During their time in hospital, they were treated by nurses, occupational therapists and clinical psychologists that were rostered on the ward for that time. Hence no real case history was established or any ongoing support offered to those sufferers. It was felt that are more strategically co ordinated approach may be more appropriate in dealing with this client base, if a greater result was to be achieved.

The eating disorders unit consists of a team of staff whose only job it is to deal with anorexic clients in the program. The team consists of the following members -

One psychiatrist.

One paediatrician.

One gastroenterologist

One occupational therapist.

One dietitian.

One clinical psychologist.

Two mental health nurses.

The program is run four days a week part time for eight weeks with a two week step down period, consisting of two days a week part time, followed up with individual sessions with a clinical psychologist or health nurse as required. Clients are generally referred through local G. P.'s, school based or private psychologists, or through referrals within the hospital from other departments. Once referred, clients are then assessed by members of the team and then placed appropriately within the program.

In the assesment of clients, there are three possible stages of malnutrition that are noted; stage one is referred to as mildly malnourished. Clients fitting into this category are invited to join the program if a place exists for them. They may return home, but must maintain a goal weight established for them by the team, and are weighed weekly to ascertain whether they are maintaining this goal weight.

Stage two is referred to as moderately malnourished. Clients fitting into this category are given two weeks to re-establish significant weight gain in the home environment, so that they can re enter the stage one category. If they can not do this then they are re admitted to hospital and tube fed until this weight gain is achieved.

Stage three is referred to as severely malnourished. Clients categorised under this heading are deemed to be needing nutritional resuscitation, are hospitalised immediately and placed on tube feeding procedures.

Clients may only join the program once they have reached stage one classification, but if they slip back into either stage two or stage three classification during the program, they may remain with the group until the program has been completed.

The program consists of mainly one hour group sessions, held by different team members over the week as follows. Cognitive behavioural therapy sessions are held three times a week with the clinical psychologist. The aim of these sessions is to challenge the patterns of thinking and behaviour that anorexic clients have developed as part of the eating disorder.

Once a week, the occupational therapist and mental health nurses hold group sessions in creative art therapy, stress management, adolescent issues, and recreational groups. The aim of these sessions is to provide the clients with a chance for discussion to look at issues of concern to them in their lives, positive role modelling, issue based client interaction, and to offer insight into client life choices.

Each client has an individual counselling session with their case manager weekly and a family therapy session with family members and the case manager if they choose to participate in this new initiative. They are also weighed and monitored by the dietitian and are expected to participate in food break/ relaxation times between sessions whilst on the program.

The EDU team meet weekly for case review and to identify issues that need to be addressed with regards to the clients progress and goals for further treatment.

Appendix B.- EAT 26 test.

Please place an (x) on the number in the column which best applies to you for each of the numbered statements. Most of the statements are directly related to food or eating, although other types of statements have been included. Please answer each question carefully.

	Always	Usually	Often	Sometimes	Rarely	Never
1. Am terrified about being over weight.	(6)	(5)	(4)	(3)	(2)	(1)
2. Avoid eating when I am hungry.	(6)	(5)	(4)	(3)	(2)	(1)
3. Find myself preoccupied with food.	(6)	(5)	(4)	(3)	(2)	(1)
4. Have gone on eating binges when I feel that I may not be able to stop.	(6)	(5)	(4)	(3)	(2)	(1)
5. Cut my food into small pieces.	(6)	(5)	(4)	(3)	(2)	(1)
6. Aware of the calorie content of foods that I eat.	(6)	(5)	(4)	(3)	(2)	(1)
7. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc.).	(6)	(5)	(4)	(3)	(2)	(1)
8. Feel that others would prefer if I ate more.	(6)	(5)	(4)	(3)	(2)	(1)
9. Vomit after I have eaten.	(6)	(5)	(4)	(3)	(2)	(1)
10. Feel extremely guilty after eating.	(6)	(5)	(4)	(3)	(2)	(1)
11. Am preoccupied with a desire to be thinner.	(6)	(5)	(4)	(3)	(2)	(1)
12. Think about burning up calories when I exercise.	(6)	(5)	(4)	(3)	(2)	(1)
13. Other people think I am too thin.	(6)	(5)	(4)	(3)	(2)	(1)
14. Am preoccupied with the thought of having fat on my body.	(6)	(5)	(4)	(3)	(2)	(1)
15. Take longer than others to eat my meals.	(6)	(5)	(4)	(3)	(2)	(1)
16. Avoid foods with sugar in them.	(6)	(5)	(4)	(3)	(2)	(1)
17. Eat diet foods.	(6)	(5)	(4)	(3)	(2)	(1)
18. Feel that food controls my life.	(6)	(5)	(4)	(3)	(2)	(1)
19. Display self control around food.	(6)	(5)	(4)	(3)	(2)	(1)
20. Feel that others pressure me to eat.	(6)	(5)	(4)	(3)	(2)	(1)

21. Give too much time and thought to food.	(6)	(5)	(4)	(3)	(2)	(1)
22. Feel uncomfortable after eating sweets.	(6)	(5)	(4)	(3)	(2)	(1)
23. Engage in dieting behaviour.	(6)	(5)	(4)	(3)	(2)	(1)
24. Like my stomach to be empty.	(6)	(5)	(4)	(3)	(2)	(1)
25. Enjoy trying rich new foods.	(6)	(5)	(4)	(3)	(2)	(1)
26. Have the impulse to vomit after meals.	(6)	(5)	(4)	(3)	(2)	(1)

Appendix C. - Rosebush Visualisation.

I'd like you to imagine you are a rosebush. Become a rosebush and find out what it's like to be a rosebush. . . . What kind of rosebush are you? . . . Are you very small? . . . Are you large? . . . Are you wide? . . . Are you tall? . . . Do you have flowers? . . . If so, what kind? . . . What are your stems and branches like? . . . Do you have thorns? . . . What are your roots like (pause) . . . or maybe you don't have any. . . If you do, are they long and straight? . . . Are they twisted? . . . Are they deep? . . . Look around you (pause) are you in the yard? . . . in a park? . . . in the desert? . . . in the city? . . . in the country? . . . in the middle of the ocean? . . . Are you in a pot or growing in the ground . . . or through cement . . . or even inside somewhere? . . . look around you (pause) . . . what do you see? . . . Other flowers? . . . Are you alone? . . . Are there any trees? . . . Animals? . . . People? . . . Birds? . . . Do you look like a rosebush or something else? . . . Is there any thing around you like a fence? . . . Does someone take care of you? . . . What's the weather like for you right now?

What is your life like? . . . How do you feel? . . . What do you experience and what happens to you as the seasons change? . . . Be aware of yourself as a rosebush . . . look carefully. Find out how you feel about your life and what happens to you.

Appendix D - Existential therapy visualisation.

Imagine you are taking a journey - a journey into space. Imagine the space capsule here in the centre of the room. You make your preparations and climb into the capsule. Now the roof is rolling back and the capsule is ready for flight. Now you begin ascending into space. You are seated by a window and, as you ascend, you enjoy the changing view. You see the (school, hospital, workshop setting) getting smaller and smaller. You see the (city, town, surrounding country side) spread out before you. It is very beautiful. You ascend still further - up and up - until you can see the curvature of the Earth and then the entire earthly sphere that we call home. As you look, images of what means most to you about our world begin to appear. Slowly your space craft begins to circle Earth. Slowly the images of what means most to you become clearer. As you travel, you are entranced as you view the shapes of the continents passing beneath you, and you are struck by the observation that there are no discernible boundaries between countries - that each merge into the other - that each is a part of a whole. As you continue to circle the Earth, you think of the world's troubles and you begin to see images of how you would like the world to be. As you continue on your journey these images of how you would like the world to be become more and more vivid. Slowly you complete the circle - slowly you begin to descend - slowly you return to this room, bringing with you the images of what means most to you, bringing with you the images of how you would like the world to be.

Appendix E. - Letter to Hospital.

To; The Head of (Name of Department)

Re; Art Therapy Research Project.

TITLE; The Mirror Within. (An art therapy research project identifying the links between anorexia, object relations and the potential role of art as the transitional object).

I am writing to ask you for permission to conduct an art therapy research project within your department, that will make up the thesis component in my Masters in Art (Art therapy) study program.

Earlier this year I undertook a placement within your department where Patients were asked to take part in art therapy sessions as part of their treatment program whilst in the eating disorders unit. At this time each participant signed a release form allowing me to use there art work for presentations, papers, research for my studies, and I am very excited about the results that were achieved.

I am keen to write the results up as part of my thesis. It is important to note that all participants understood that they would not be identified in my research in any distinguishing way and that they had the right to withdraw their consent at any stage during the project.

It is also important to note that the research I am proposing is not associated with related changes in eating or behavioural patterns that clients may have developed since taking part

in the eating disorders unit program. It merely investigates how art created by anorexic clients reflects their condition through the use of lines, colour and art work themes.

I am happy to discuss any conditions that your ethics committee may wish to impose on the research, as you see fit and can be contacted on the below number during office hours.

Attached to this letter is a copy of the proposed abstract for the thesis. I look forward to your response.

Yours sincerely,

Appendix F - Correspondence from Hospital.

COPY

17 July 1997

Dr Brett McDermott
Child and Adolescent Psychiatrist

Mr Rod Crothers
Chairman Edith Cowan University Ethics Committee

Dear Mr Crothers,

Re: Research proposal, Bronwen Gray Masters in Art Therapy

Ms Gray has approached me, in my capacity as the Director of the Eating Disorders Team, to use clinical material that she collected whilst on placement with the Team, for the use as data in her masters thesis.

I have discussed the material in question. It consists of art work completed by EDT clients during their creative expression sessions. I note that Ms Gray has collected signed consent forms from the patients in question to use this material for future research and publication, providing that they cannot, in any way, be identified as the author of that material.

On these grounds, providing the research proposal meets the other criteria of your ethics committee, I have no problems with Ms Gray using this material. I note that there is the issue of ownership of the art work following its use in research. Whilst control group art work is clearly not a matter for myself, it is my opinion that art work from the creative expression group of the EDT therapy program should be offered back to the author of the work or should be held by the EDT therapy staff.

I would be happy to discuss this with you further.

Yours sincerely,

Brett McDermott.

Appendix G - correspondence to School.

To;(name of principal)

Re; Art Therapy Research Project.

Dear _____

I am writing to ask you for permission to conduct a component of an art therapy research project within your school, that will make up the thesis component in my Masters in Art (Art therapy) study program.

This research is being conducted with the assistance of staff from (name of hospital), who have identified anorexia nervosa as affecting a growing number of young people in our society.

Earlier this year I undertook a placement at this hospital working with teenage clients suffering from anorexia nervosa. Clients were asked to take part in art therapy sessions as part of their treatment program whilst in the eating disorders unit.

The works they produced are to become the basis for my thesis proposal and I am keen to compare the works they made with works that other teenagers, not suffering from anorexia may make.

If you are willing to assist in this research project, it would involve allowing me to run three art therapy sessions, of approximately one hour duration, with a small number of female students from your school, to be identified by the school psychologist. Their works

would then be compared side by side with the works made by anorexic clients, to look for similarities and differences in picture construction.

The three art exercises that students would be asked to take part in have all been chosen because they are designed to encourage positive self regard and to develop self esteem. They have not been chosen because they are associated with anorexia nervosa or diet related issues.

Although it is extremely unlikely that the exercises would make students feel uncomfortable, there may be the possibility that students might start to scrutinise their own eating habits in a way that they have not done previously. As part of a proposed management plan for this developing, I would be happy to work with the class co ordinator, to run some education sessions around anorexia nervosa, that would help to alleviate any fears.

I would also work closely with your school psychologist, so that any students who appeared to be having difficulty in processing the art exercises could be followed up on a one to one basis with this staff member. Of course, I would like to stress that I believe that this eventuating is highly unlikely, and that all care for your students is my first consideration.

With regards to the benefits of taking part in the project, it may be that students develop a renewed or more responsive self awareness and as a result of the exercises and find that they feel stronger or happier, or find that it is easier to recognise and express their own feelings to self and others.

Your school's participation in this project would be of great significance in research addressing teenage mental health issues.

It is important to note that no participants will be identified in the research in any distinguishing way and that they have the right to withdraw their consent at any stage during the project.

It is also important to note that I am not suggesting that clients drawn from your school are being chosen because they are in some way associated with the above mentioned condition. It will merely provide the opportunity to compare the art created by anorexic clients with works made by non anorexic sufferers.

Attached to this letter is a copy of the proposed abstract for the thesis. I am happy to discuss any concerns that you may have about the project and can be contacted on the number below, during school hours or you can contact my supervisor (name of supervisor) on_____. I look forward to your response.

Yours sincerely,

Appendix H. - Art therapy release form.

ART THERAPY RELEASE.

At times, I am asked to present information on Art Therapy to professional and educational groups at meetings, conferences, training facilities, workshops and seminars and/or in professional publications. When client's cases and/or art work are part of these presentations, the anonymity of the client is protected through the elimination of and/or changing of identifying information (for example, your name will not be shown in any way.) These cases and/or art work or reproductions of the art work are used for the purpose of education, training and/or research.

Yes, I give permission to _____ by my signature below to use my case and/or art work/ reproductions for education, training and/or research.

Client signature.....Date.....

Witness signature.....Date.....

Appendix J. Letter to group B participants explaining project (to be read before signing of release form, appendix I)

HI!

My name is Bronwen, and I am an art therapy student at Edith Cowan University, undertaking a research project that looks at issues surrounding teenagers and eating disorders. (name of school) has agreed to let me conduct part of my research at your school this term, and you are being invited to take part in the study.

At (name of school) I am going to be working with a small group of healthy, happy young people who will be invited to take part in some art exercises, the results of which will be compared with works created by other young people of a similar age who are presently hospitalised with a chronic eating disorder.

If you agree to take part in the study, you will be asked to firstly undertake a short questionnaire that looks at your attitudes to food, and then to take part in 3 art exercises that have been developed to encourage positive self esteem. Along with (name of school psychologist) I will also be running a general information session about the project, so if you have any questions, they can be asked and discussed at this time.

If you would like to take part in the research, you must understand the following-

1. The work you create may be published as part of my research, but if it is, you will not be identified as the owner of this work in any way what so ever. It will be completely anonymous.
2. You have the right to ask questions of me about the project at any time during the term, and you can withdraw your permission for use of your drawings at any time you may desire.

3. The work you create will remain your property, and will be returned to you at the completion of the project to do what you want with it.
4. Your parents will also be asked to sign a release form, saying that they agree to letting you participate in the research.
5. You will need to sign the attached form that gives your consent to being involved in the project.

The art exercises will last for approximately one hour each and will be held over a three week period. You don't need to be good at art to do the exercises, just a willingness to have a go. (name of school psychologist) will also be participating in the classes, so if you feel that you need to discuss what you draw in the three week project in more detail, then you can also make a time to meet with her and talk about your work.

Although limited, your participation in this research would be contributing something that could have far reaching consequences for young women in our community in the future and would be greatly appreciated.

Please feel free to contact me about this project if you have any questions or would like to know more about how it turns out, or you can ask (name of school psychologist) for more information.

Thanks!

Appendix I Letter to be given to Group A participants prior to signing release forms.

Dear _____,

As you know, I have been a student on placement at (name of hospital) for the last two months and that the work I have done with you has been part of my course in training to be an art therapist.

For the next part of my study, I must write about anorexia and how art therapy has been used in this hospital, the results of which will be published by the University. I am asking for your permission to use some of your drawings in this research, so that people who read my thesis can not only *hear* about how art therapy was undertaken in this hospital, but can *see* the results of it too.

If you are prepared to let me use some of your art work in this document, you will need to sign the form attached to this letter, but it is also important for you to know the following -

1. If I do use any of your art works, you will not be identified as the owner of this work in any way what so ever. It will be completely anonymous.
2. You have the right to ask questions of me about the project at any time during our time together, and you can withdraw your permission for use of your drawings at any time you may desire.

If you would like to know more about my project and what will happen with it once we finish these groups together, please feel free to call me on _____, or you can ring my supervisor, (name of supervisor) on _____.

Thank you for your assistance.

Appendix K - Letter to parents.

Dear parent,

My name is Bronwen Gray and I am a Masters student studying art therapy at Edith Cowan University. (name of school) has agreed to assist me with the thesis component of my study, by allowing me to undertake research in the school that addresses concerns in adolescent mental health issues. The proposed 3 week project will take place this term and will look specifically at teenagers and eating disorders.

For this research project, (name of school) has agreed to assist me by allowing a group of, healthy, happy young people to take part in some art exercises, the results of which will be compared with chronic eating disordered clients of similar age who are presently hospitalised with the illness.

The research I will be undertaking will involve the running of three art therapy sessions, of approximately one hour duration, with a small number of female students in the school, ages between 13 and 16. The art exercises that they will undertake will be geared towards imagining a positive self image, and encouraging a healthy outlook on life. It will also be necessary for your child to complete a short questionnaire in the first week of the project that looks at their attitudes towards eating and dieting.

The sessions will be supervised by (name of school psychologist) your school psychologist who is supportive of the project and will be available to spend time with students after the art exercises, if any student feels that they may need some additional time.

The works that these students make will then be compared side by side with the works made by eating disordered clients, to look for similarities and differences in picture construction. The results of the project will be written up as part of my Masters in Art Therapy thesis project and will be lodged with the Eating Disorders Unit, for further use.

Your child's participation in this project would be of great significance in research addressing teenage mental health issues.

It is important for you to know that no child will be identified in the research in any distinguishing way and that they have the right to withdraw their consent at any stage during the project.

It is also important to note that we are not suggesting that your child has been chosen to take part in the project because they are in some way associated with the above mentioned condition. It will merely provide the opportunity to compare the art created by eating disordered clients with works made by non eating disordered young people.

If you are happy for your child to take part in this project, you will need to sign the consent form attached to this letter, and send it back to (name of school psychologist) by (date). If you would like to know more about the project, you can contact me on _____ between 4.30 and 7.30. pm on any week night or you can contact (name of school psychologist) at the school on _____

Yours sincerely,

Appendix L - Consent form for Parents re child's participation.

RE: Anorexia Nervosa Art Therapy research project.

CONSENT FORM

I _____ (name of parent or guardian) have read the information regarding the proposed art therapy project and agree to my child _____ (name of child) participating in this research.

I understand that my child will not be identified in any way in the published material, and that my child has the right to withdraw from the project at any time without prejudice.

I also understand that I have the right to ask questions regarding any aspects of the research at any time that I desire.

Signature of parent or guardian

Date.