Art Therapy with an Eating Disordered Male Population: A Case Study

A Thesis

Submitted to the Faculty

of

Drexel University

by

Elizabeth Helen Beck

in partial fulfillment of the

requirements for the degree

of

Master of Arts in Creative Arts in Therapy

July 2007

Acknowledgments

The writing of this thesis would not have been possible without the advice and direction of my thesis advisor, Betty Hartzell, Ph.D., ATR-BC, LPC, as well as my thesis committee members Susan Kaye-Huntington Psy.D., ATR-BC, LPC and Shilpa Saroop Ph.D. I would also like to thank Mom, Dad, Grandpa Pista, Grandma and Grandpa Ruby for all their support and guidance throughout my years of education. Lastly, I would like to dedicate this writing to David Birnbaum, who has been an integral part of my writing process. Thank you for continually encouraging and inspiring me.

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Abstract

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Despite a number of studies found throughout the psychological literature, only four case studies have been published regarding an eating disordered male in the context of art therapy treatment. An exploratory qualitative case study design was used in order to address the following research questions: What is the process of art therapy treatment with the eating disordered male, as seen through the subject? What is the nature of the artwork produced by the eating disordered male, as seen through the subject? The objectives of this case study were to explore the art therapy process, describe the symbolism contained in the artwork, and gather additional information regarding the nature of eating disorders in men. This case study included one anorexic male who met the research criteria of being between the ages of 18 and 60, and who was hospitalized for at least a one week, allowing for the completion of three individual art therapy sessions. The subject's artwork corresponded to several conflicts present in the artwork of eating disordered females in the literature. For example, conflicts regarding family relationships and denial of the body seemed to emerge in the artwork and verbalizations. The findings also suggest that the patient struggled with his sexual identity, which is a common feature of men with eating disorders. Future studies will need to corroborate the findings of this study, as well as extend the research period beyond a one week period, in order to record artistic

changes that may occur throughout the re-feeding process. The results also implied that further research is needed in regards to the transferential relationship between a female therapist and a male anorexic patient. As this study only included one male diagnosed with anorexia, more research is needed to explore the art therapy process and symbolism of men diagnosed with bulimia, eating disorder NOS, or binge eating disorder.

CHAPTER 1: INTRODUCTION

Reports of eating disorders have been increasing over the past few decades, affecting not only young women, but also prepubescent girls, middle-aged women and men. Recent studies have indicated that up to 4% of adolescent and young adult students have received an eating disorder diagnosis (Sadock & Sadock, 2003). The prevalence of eating disorders in males is still being studied. According to Braun, Sunday, Huang & Halmi (1999), males account for 5 to 10% of cases of anorexia and 10 to 15% of bulimia cases. Sadock and Sadock (2003) offer more conservative estimates stating that anorexia "occurs 10 to 20 times more often in females than in males" (p. 739) while for bulimia, "the rate of occurrence in males is one-tenth of that in females" (p. 747). The common age of onset for anorexia is between 14–18 years of age, while for bulimia the onset often occurs in later adolescence or early adulthood (Sadock & Sadock, 2003).

The purpose of this case study was to gather additional information regarding the nature of eating disorders in men. Despite a number of studies found throughout the psychological literature, only four case studies have been published regarding an eating disordered male in the context of art therapy treatment. Therefore, there is a large gap within art therapy literature concerning the eating disordered male. It is hoped that by examining eating disorders in males through the eyes of art therapy, the information found will contribute to current psychological research and treatment approaches, as well as possibly reveal new questions or areas of study. Furthermore, since the art therapy literature is sparse regarding this subject, an additional purpose of this study was to record the nature of the art therapy process and artwork produced, including its symbolism and verbal processing. These findings were compared to the existing literature regarding females and males with eating disorders and art therapy.

The study allowed for a maximum of three male subjects between the ages of 18 and 60, who were undergoing inpatient treatment at Friends Hospital to be recruited and participate in three individual art therapy sessions each during the course of the study, although only one male subject completed the study. The major features of the study follow the guidelines set by Mertens (2005) regarding qualitative case study research, which includes an examination of the art therapy process and artwork produced, as well as a description of the subject's historical background, physical setting, treatment history, therapeutic process, dynamics, progress and aesthetic aspects of the cases. The information gathered from these individual sessions were analyzed and compared to the existing literature regarding women with eating disorders and art therapy.

There is currently a debate taking place within psychological literature regarding the possible differences between men and women who have been diagnosed with an eating disorder (Carlat, Camargo & Herzog, 1997). Although several possible risk factors such as homosexuality, high involvement with sports, and concerns with obtaining a masculine shape (Muise, Stein & Arbess, 2003) have been investigated, little information has been identified or examined from an art therapy perspective. As Carlat et al. (1997) described,

> From a clinical standpoint, there is a need for practical information on males with eating disorders to help guide diagnostic and treatment decisions. From a theoretical standpoint, the study of males with eating disorders contributes useful information to the question of eating disorder etiology. (p. 1127)

Therefore, examining the art therapy process and the artwork of men with eating disorders will aid in the overall understanding of the nature of eating disorders, as well as contribute to the subject of treatment planning for this specific population.

Although Dr Richard Morton first reported a case with an eating disordered male in 1689 (Carlat et al., 1997), the psychological community only began focusing on this topic in the 1980s. According to Braun et al. (1999), males account for 5 to 10% of cases of anorexia and 10 to 15% of bulimia cases. Several articles suggest that the clinical presentation of males with eating disorders is similar to their female counterparts (Muise et al., 2003; Geist, Heinmaa, Katzman & Stephens, 1999; Woodside, Garfinkel, Lin, Goering, Kaplan, Goldbloom & Kennedy, 2001). However, as mentioned above, several risk factors and differences in the psychosocial histories of men with eating disorders are currently being debated and examined. For example, according to J. A. Farrow (1992), men tend to have a premorbid history of obesity, sexual identity concerns, as well as dieting in relation to sports teams. Muise et al. (2003) conducted a review of the existing literature regarding eating disordered males. Similar to Farrow (1992), they found several risk factors, including a history of obesity, involvement with sports, and homosexual or bisexual orientation.

Within the art therapy literature, eating disorders have been widely discussed though only specifically in relation to the presentation, symbolism and treatment of females. For example, Johnson & Parkinson (1999) discussed the treatment of females with eating disorders in a group setting, useful interventions and art materials for this population, as well as the types of images they have found to be typical of the women who have presented within their art therapy groups. Furthermore, Rehavia-Hanauer (2003) qualitatively examined the underlying socio-cultural, psychological, family and developmental factors that may lead to an eating disorder in females through the systematic examination of art therapy session summary reports. However, only four case studies discuss the use of art therapy with eating disordered males. Therefore, due to the lack of existing art therapy literature regarding eating disorders and males, along with the need for more information regarding this population, the examination

of eating disordered males from an art therapy context is merited.

The small number of subjects recruited delimits this case study, as well as the exploratory nature of this study. Therefore the results are not generalizable to the population at large. Although the onset of eating disorders commonly occurs in females during adolescence, the onset of eating disorders in males typically manifests in one's early twenties (Braun et al., 1999). For this reason, the inclusion criteria for this study included a maximum of three male subjects between the ages of 18 and 60, who were undergoing inpatient treatment at Friends Hospital. Furthermore, qualifying subjects would participate in three individual art therapy sessions each during the course of the study. Due to these boundaries, the results of this case study cannot be generalized to males under the age of 18 years, males who are above the age of 60, or males receiving art therapy for more than a one-week period. Although Friends Hospital accepts men in their eating disorders clinic, and the number of men seeking treatment has been rising since the 1980s (Braun et al. 1999), only one qualifying anorexic male was admitted for inpatient treatment during the time period of the study. Future studies are needed to include additional data in order to support the findings of this case study.

The research questions for this case study were as follows: What is the process of art therapy treatment with the eating disordered male, as seen through the subject? What is the nature of the artwork produced by the eating disordered males, as seen through the subject?

The objective of this case study was to explore the nature of the art therapy process with a maximum of three male subjects diagnosed with an eating disorder and to describe the symbolism used within the artwork. A further objective is to compare the artwork of the subjects to females with eating disorders who have been previously discussed within art therapy literature.

CHAPTER 2: LITERATURE REVIEW

Overview

An eating disorder diagnosis is one of the top ten leading causes of disability amongst young women (Striegel-Moore & Bulik, 2007), affecting approximately 5 to 10 million people in the United States (Rayworth, Wise & Harlow, 2004). In addition, eating disorders have been associated with the highest levels of treatment seeking, inpatient hospitalization, suicide attempts and mortality when compared to other psychiatric diagnoses (Stice, 2002). Body image, dieting, cultural values, genetic factors and social experiences are some of the proposed risk factors implicated in the development of an eating disorder (Striegel-Moore & Bulik, 2007, Haines & Neumark-Sztainer, 2006). Given these risk factors, it is an alarming fact that approximately 15% of children and teens between the ages of 6–19 are overweight. Furthermore, in 2003, the Youth Risk Behavioral Surveillance System (YRBSS) reported that 60% of female and 29% of male high school students were actively trying to lose weight. It is estimated that between 20–56% of girls and 31–39% of boys between the ages of 6–11 were on a diet and approximately 11% of high school girls and 7% of high school boys reported taking diet pills, powders or liquids to lose weight. In addition, in 2003, 8% of girls and 4% of boys reported vomiting or taking laxatives in the past month (Haines & Neumark-Sztainer, 2006).

Recent studies have indicated that up to 4% of adolescent and young adult students have received an eating disorder diagnosis. The common age of onset for anorexia is between 14–18 years of age, while for bulimia the onset tends to occur in later adolescence or early adulthood (Sadock & Sadock, 2003). The National Comorbidity Survey Replication study found the lifetime prevalence rates for anorexia

nervosa to be 0.3% in men and 0.9% in women, and the lifetime prevalence rate for bulimia nervosa was found to be 0.5% in men and 1.5% in women (Striegel-Moore & Bulik, 2007). Furthermore, population based studies of binge eating disorder, which is included in the diagnosis of eating disorder NOS (not otherwise specified), estimate the prevalence rate to be between 0.7 and 3.0% (Berkman, Lohr & Bulik, 2007). Binge eating disorder has been found to be equally as common in men as in women (Striegel-Moore & Bulik, 2007).

Anorexia Nervosa

Both William Gull in Great Britain and Charles Lasgue in France introduced anorexia nervosa as a new illness almost simultaneously in the late 1800s (Striegel-Moore & Bulik, 2007). Over one hundred years later, the Diagnostic and Statistical Manual 4th edition, third revision (DSM IV TR) proposed the following criteria for the diagnosis of anorexia nervosa: 1) refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected, or a failure to make expected weight gain during a period of growth leading to body weight less than 85% of that expected), 2) intense fear of gaining weight or becoming fat, even though the individual is underweight, 3) disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape evaluation, or denial of the seriousness of the current low body weight, and 4) in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. There are two subtypes for this disorder: restricting and binge eating. However, in the literature reviewed, the two subtypes are usually discussed together, making it difficult to discern between what may be two separate etiological disorders since the binge eating subtype seems to correspond symptomatically with bulimia nervosa.

According to Sadock & Sadock (2003) individuals diagnosed with anorexia tend to have little interest in sex, as well as bizarre eating habits such as hiding food, carrying large amounts of candy, cutting up food into small pieces and moving it around on the plate and/or refusing to eat in front of others. Appetite is present in the early stages of the disorders, which speaks towards the amount of control and repression these individuals must exert in order to carry out their self-starving behaviors. Lavender, Shubert, de Silva & Treasure (2006) point out that similarities have been observed between those with obsessive compulsive disorder (OCD) and those with eating disorders, particularly with individuals diagnosed with anorexia nervosa. The restrictive subtype tends to exhibit obsessive-compulsive traits, where up to 26% of individuals with a diagnosis of anorexia nervosa also have a comorbid diagnosis of obsessive compulsive disorder (Sadock & Sadock, 2003). Using the Magical Ideation Scale (MIS) and the Obsessive Beliefs Questionnaire (OBQ), Lavender et al. (2006) compared an eating disorder group with recovered eating disordered subjects, subjects with OCD, and an anxious group. The results indicated that on the MIS scale, the eating disorder group scored similarly to those with OCD, and on the OBQ scale they scored higher than those with OCD, suggesting that individuals with eating disorders have more obsessive beliefs than those with OCD. Intriguingly, while 91% of the eating disorder group reported experiencing intrusive thoughts, only 7% reported those thoughts to surround eating, weight or body shape. The results may imply that in many cases, treatment of eating disorders should include the management of obsessive and compulsive belief systems. In addition to obsessions and magical thinking, depression occurs in up to 65% of cases of anorexia. Social isolation, high academic achievement, and the lack of a sense of self are widespread amongst those diagnosed with anorexia nervosa. Lastly, the symptoms of anorexia are experienced as ego syntonic, where behaviors, emotions and thoughts are experienced as accept-

able to the ego or to one's self-image, making resistance to treatment a considerable obstacle (Sadock & Sadock, 2003).

Individuals who have been diagnosed with anorexia nervosa are subject to a number of health risks and problems due to lack of caloric intake. The health implications of this disorder are extremely serious and may lead to death. For example, reduced thyroid metabolism, loss of cardiac muscle, cardiac arrhythmias, bloating, constipation, abdominal pain, amenorrhea, mild cognitive disorder and osteoporosis are common complications (Sadock & Sadock, 2003). Decreases in brain, kidney, ovary and uterus size have also been observed, although once the individual has returned to a healthy weight these organs return to their normal sizes. However, this does not imply that the tissue has been fully restored, meaning that permanent damage to the neurological structure may have occurred (Harris & Cumella, 2006).

As stated previously, anorexia nervosa is associated with the highest mortality rate of any psychiatric disorder, between 10 and 15% (Rayworth, Wise & Harlow, 2004, Hoek, 2006). In studies that recorded the cause of death of anorexics, over 50% of deaths were associated with eating disorder health complications, 27% of deaths were due to suicide, and approximately 20% of deaths were due to unknown causes (Sullivan, 1995). Despite this fact, working with an anorexic individual can be extremely difficult since they are often secretive or deny the symptoms of their disorder. Individuals with anorexia nervosa are highly resistant to treatment, making the establishment of a therapeutic alliance of primary importance after health related concerns have been managed (Sadock & Sadock, 2003).

The prognosis for anorexia nervosa is usually poor; however, it varies from person to person. Some individuals spontaneously remit from their symptoms without experiencing a further episode, while others wax and wane throughout life, or perhaps even until their death due to medical complications of the disorder (Sadock & Sadock,

2003). A literature review conducted by Berkman, Lohr & Bulik (2007) discussed a small number of longitudinal studies that measured the outcome of anorexia nervosa over an approximately 10-year period. Their findings were as follows: a study in Göteborg, Sweden found that over 50% of individuals were considered to have a good outcome on the Morgan Russell (M-R) General Scale after receiving a diagnosis of anorexia 10 years ago. A study conducted in New Zealand that measured the recovery rates of female patients demonstrated that 30% of the study group were fully recovered after 12 years of follow up, while 21% were still considered to have an eating disorder and 10% were found to meet the diagnostic criteria for anorexia nervosa. Similarly, a U.S. study found that approximately 27% of individuals who received a diagnosis of anorexia nervosa had reached full recovery at 10 years of follow up.

It has been hypothesized that difficulties surrounding both early nurturance and the separation and individuation phase underlie the psychodynamics of individuals who suffer from anorexia (Lubbers, 1991; Sadock & Sadock, 2003). Many anorexic individuals describe the belief that oral desires or the desire for nurturance is unacceptable, causing the use of rigid defense mechanisms in order to deny these wishes (Sadock & Sadock, 2003). Furthermore, object relations theory proposes that the anorexic identifies her[1] body as the internalized bad mother. This internalization, having not been integrated in her psyche, causes the anorexic to misinterpret the physical changes of puberty as a direct attack by the internalized mother to completely devour her. The anorexic then responds by controlling her body through excessive dietary restriction and exercise as a way of fighting back against the all-consuming mother (Rehavia-Hanauer, 2003).

In terms of the family system, it has been observed that enmeshed relation-

[1]The word *her* is used throughout this and subsequent sections because the reviewed theories and studies principally discuss the anorexic individual as "she". This may suggest that the conceptualization of theories regarding eating disorders are gender biased.

ships with one's caregivers are common in individuals with this diagnosis (Rehavia-Hanauer, 2003). For example, the mother is often regarded as dominating, intrusive or unempathic by the child (Sadock & Sadock, 2003). The family itself may strive to appear "perfect" at all times. Furthermore, it is hypothesized that the resolution of the separation and individuation phase was not permitted since the parents of the anorexic approached this period with control and rigidity, rather than with flexibility (Lubbers, 1991). One might therefore deduce that the concept of independence had been given a negative connotation from a young age. Consequently the anorexic struggles to find her sense of identity as well as to reclaim power and control over the family conditions (Bruch, 1974). Furthermore, since autonomy is connected to rejection or harm of the child/caregiver relationship, ambivalence towards the notion of dependence seems to play out in the everyday dynamics of mealtime for the anorexic. Through the defense of acting out, the anorexic starves him/herself in order to symbolize the perceived emotional malnourishment (Schaverien, 1995).

When considering the family component in the commencement and maintenance of eating disorders, one must also bear in mind the emotional reaction of the family itself when a member is diagnosed with an eating disorder. Ball & Ball (1995) describe that families may experience "concern, despair, frustration, anger, confusion and guilt" (p. xiii). Furthermore, Hillge, Beale & McMaster (2006) describe that due to the chronic nature of eating disorders many families directly involved with the care and maintenance of everyday events for their loved ones may report caregiver burden or caregiver isolation, where they may describe feeling trapped by the current situation. Parents tend also to report emotional pain and embarrassment, as well as a fear of being ostracized by health care professionals due to the fact that many health care providers believe eating disorders originate in the family system. In their study, Hillge et al. (2006) conducted semi-structured interviews with 19 mothers and three

fathers of children and teenagers diagnosed with an eating disorder in Australia. The discussions were analyzed for common themes, which included: 1) family unification or disintegration, where the eating disorder may have brought families together after a period of turmoil or ultimately fractured family relationships, 2) the parents' inability to cope, which was expressed through metaphors like "breaking my heart" or "tearing me apart", 3) inconsiderate comments from significant others, which occurred for example when family or friends made either positive or negative comments regarding weight or body shape of the loved one with an eating disorder, 4) social isolation from family, friends and healthcare professionals, which resulted in having the burden of raising an ailing child alone and promoting the attitude of "keeping it in the family" thereby depleting their emotional resources. Lastly, Hillge et al. found that financial impacts were common amongst the families interviewed, where the treatment of their child's eating disorder resulted in high amounts of monetary expenditure, although no family spoke of feeling resentful of this fact. Instead most families spoke of the stress of worrying that their insurance benefits would run out and were unsure how they would subsequently pay for their loved one's continual treatment. Hillge et al. conclude their study by encouraging health care providers to regard families as a resource that can aid in the recovery of the patient. Additionally, it should be noted that this study does not make references to families that have a history of being chaotic or abusive environments, which would result in a different therapeutic approach.

Sociocultural theories have also been proposed to explain the development of anorexia and eating disorders in general. These models tend to emphasize the dominant culture's ideal of the female body, characterized as increasingly and unrealistically thin. These paradigms argue that when a woman internalizes the media-constructed thin ideals, the person begins to compare herself to the cultural ideal,

making her likely to experience a discrepancy between the self and the ideal. This may in turn lead to body dissatisfaction and eating disorder behaviors (Striegel-Moore & Bulik, 2007). See the subsection entitled Risk Factors of Eating Disorders for further explanation.

Bulimia Nervosa

Both Boskind-Lodahl (1979) and Russell (1979) distinguished bulimia nervosa as a separate disorder from anorexia nervosa, although Russell commonly receives credit for the conceptualization of the disorder (Striegel-Moore & Bulik, 2007). The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) included this diagnosis within its parameters in 1980 (Hoek, 2006). Over 25 years later, the DSM IV TR proposes the following criteria for bulimia nervosa: repeated episodes of binge eating, characterized by both of the following: 1) eating, in a discrete period of time, an amount of food that is larger than what most people would eat during a similar period of time and under the similar circumstances, 2) a sense of lack of control over eating during the episode. Furthermore, the individual must also exhibit recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months. In addition, self-evaluation is unduly influenced by body shape and weight and the disturbance does not occur exclusively during episodes of anorexia nervosa. There are two subtypes identified by the DSM IV TR, purging and nonpurging. The purging subtype is marked by the current use of self-induced vomiting or the use of laxatives, diuretics or enemas. The nonpurging subtype is diagnosed when an individual is currently fasting or overexcerising, but not engaging in self-induced vomiting, the use

of laxatives, diuretics or enemas. Furthermore, according to Sadock & Sadock (2003), the majority of individuals diagnosed with bulimia nervosa are of a normal weight. Bulimics who do not purge are more likely to be obese and have less body-image disturbance than the purging type.

There are several medical complications that are associated with bulimia nervosa, which are also considered to be serious health risks. For example, the common medical effects related to purging and laxative abuse are electrolyte imbalances, salivary gland and pancreatic inflammation, esophageal and gastric erosion, erosion of dental enamel, tooth decay, seizures, mild neuropathies, fatigue, weakness and mild cognitive disorder (Sadock & Sadock, 2003).

Individuals diagnosed with bulimia tend to be high achievers and are hypothesized to respond to social pressures to be thin. In contrast to anorexics, bulimics tend to be overly concerned with how others perceive them, including sexual attractiveness. Bulimia is often found to be comorbid with mood disorders such as depression and bipolar I, impulse control disorders, dissociative disorders, substance related disorders, anxiety disorders and personality disorders. Furthermore, individuals diagnosed with bulimia are often more impulsive and outgoing than anorexics. These individuals tend to experience their symptoms as ego dystonic, where as anorexics commonly describe their symptoms as being ego syntonic, making bulimics more likely to seek treatment (Sadock & Sadock, 2003).

Psychodynamically, the symptoms are explained by a hypothesis that bulimics have less superego control and ego strength than individuals with anorexia. This may be linked to the associations between bulimia and alcohol dependence, shoplifting, destructive sexual relationships and emotional lability. Furthermore, many of these individuals describe having neglectful, rejecting parents, and chaotic home environments. It is theorized that eating corresponds to nurturance or a wish to fuse

with the caretaker, while purging symbolically represents an unconscious wish for separation (Sadock & Sadock, 2003).

An abnormal eating pattern seems to be one of the most important aspects of bulimia nervosa. Binge eating, or uncontrolled food intake, seems to occur while "the person experiences an irresistible food craving and lack of control over his or her eating behavior" (Mauler, Hamm, Weike & Tuschen-Caffier, 2006, p. 567). Subsequently, to prevent weight gain and negative cognitions, the individual participates in inappropriate compensatory behaviors, such as purging, over-exercise and/or laxative use. In fact, Stein et al. (2001) describe the CBT model of bulimia nervosa as,

> Based on the assumption that considerable initial concern about weight and shape, with low self-esteem as a potential initial or maintaining factor, results in dietary restraint. Due to the increased hunger and deprivation associated with restraint, it is inevitable that dietary rules are broken, often resulting in an abstinence-violation effect that leads to binge eating. These problematic cognitions, attitudes, and behaviors solidify into a continuing cycle of binge eating and compensatory behaviors (usually self-induced vomiting) that characterize [bulimia nervosa]. (p. 704)

Binge Eating Disorder/Eating Disorder NOS

Eating disorder NOS is the third sub classification for eating disorders in the DSM IV TR, which currently envelops the diagnosis of binge eating disorder. Striegel-Moore & Bulik (2007) discuss the fact that the categorization of NOS is intended to portray a residual group of individuals who do not meet the criteria of the major sub classifications of anorexia nervosa and bulimia nervosa. However, there is a higher percentage of individuals who have received a diagnosis of eating disorder NOS than the previously mentioned diagnoses, perhaps due to the fact that many individuals

seem to binge eat without compensatory behaviors or subsequent dietary restriction. Population-based studies have found the prevalence rate of binge eating disorder to be between 0.7% and 3.0% (Brownley, Berkman, Sedway, Lohr & Bulik, 2007). Furthermore, binge eating disorder seems to be affecting people of all ages, sexes and ethnic backgrounds (Harris & Cumella, 2006). Therefore, researchers are advocating a new classification of binge eating disorder to be officially added to the next revision of the DSM. Currently, the DSM IV TR has included research criteria for binge eating disorder.

The DSM IV TR includes examples of what constitutes eating disorder NOS: 1) For females, all the criteria for anorexia nervosa are met except that the individual has regular menses, 2) All of the criteria for anorexia are met except that, despite significant weight loss, the individual's current weight is in the normal range, 3) All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months, 4) The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies), 5) Repeatedly chewing and spitting out, but not swallowing, large amounts of food, 6) Binge eating disorder, defined as recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of bulimia nervosa.

Risk Factors of Eating Disorders

There are several risk factors that seem to contribute to the development of anorexia nervosa. Striegel-Moore & Bulik (2007) define a risk factor as,

> A characteristic (e.g., allele), event (e.g., teasing), or experience (e.g.,

> growing up in a culture that values extreme thinness) that precedes the onset of the outcome of interest (e.g., an eating disorder) and that, 'if present, is associated with an increase in the probability (risk) of a particular outcome over the base rate of the outcome in the general population'. (p. 183)

The authors caution the reader by stating that risk factor studies often have not been consistently replicated, and may include methodological errors and low effect sizes. Therefore, one must practice caution to avoid generalizing the following findings.

Striegel-Moore & Bulik (2007) consider the identification of risk factors important for several reasons. For example, knowledge of risk factors aids researchers and those in the field of mental health to conceptualize the reasons why some people develop an eating disorder while others do not. In addition, the subclassifications of anorexia nervosa, bulimia nervosa and eating disorder NOS are currently being debated due to the fact that the groupings have been conceptualized based on initial clinical presentation, while failing to account for symptom changes over time. For example, it is not unusual for crossover in symptoms to occur over the duration of an eating disorder. That is to say, some people sway back and forth using both restricting and purging or other compensatory behaviors within days, months or years of each other throughout the lifespan of an eating disorder. Furthermore, as stated previously, the classification eating disorder NOS is intended to capture a residual group of individuals who do not meet the criteria of the major sub classifications of anorexia nervosa and bulimia nervosa. However, there is a higher percentage of individuals who have received a diagnosis of eating disorder NOS than the aforementioned diagnoses. For this reason, many researchers are advocating for a new classification of binge eating disorder to be officially added into the next revision of the DSM. Understanding the risk factors

of eating disorders may lead to the understanding of its etiology, which will allow for more accurate sub classifications and perhaps more precise and targeted treatments. Lastly, the identification of risk factors may also allow for preventative programs to be formed, as well as possible changes to public policy.

To date, the most powerful risk factor for developing an eating disorder is being female (Jacobi, Hayward, de Zwaan, Kraemer & Agras, 2004; Striegel-Moore & Bulik, 2007). Therefore, most studies include only women in their cohorts. However, there seems to be a growing trend to include both men and women in more recent studies regarding eating disorders. Striegel-Moore & Bulik (2007) suggest that the classification system used to identify eating disordered individuals may be gender biased. When weight, shape concerns and extreme compensatory behaviors are excluded from the diagnostic criteria the difference in the female : male prevalence ratio becomes less pronounced. In addition, Carlat et al. (1997) point out that research regarding males with eating disorders will contribute to the understanding of eating disorder etiology, since the prevalence of eating disorders in men is between 10 to 20 times less than in females (Sadock & Sadock, 2003).

The majority of researchers would agree that both anorexia nervosa and bulimia nervosa typically manifest during adolescence, making adolescence a risk factor for developing an eating disorder (Jacobi et al, 2004; Striegel-Moore & Bulik, 2007). Late onset anorexia or bulimia is considered rare. However, this pattern does not seem to hold true for binge eating disorder, where onset in adulthood has often been reported. Several studies have found that a higher socioeconomic status may be a risk factor for the development of anorexia nervosa, although this was not found to be the case for bulimia nervosa. Furthermore, it is generally believed that eating disorders are rare amongst ethnic minorities in the United States, although most studies fail to include indication of race/ethnicity in their outcome measurements (Striegel-Moore & Bulik,

2007).

Stice (2002) reviewed studies pertaining to the following risk factors: body mass, social modeling, thin-ideal internalization, body dissatisfaction, dieting, negative affect, perfectionism, early menarche and impulsivity. Of these proposed risk factors, body dissatisfaction emerged as a risk factor for initiating dieting behavior. Indeed, according to Haines & Neumark-Sztainer (2006), many individuals with eating disorders report that dieting behavior precipitated the onset of eating disordered behavior. In addition, Stice (2002) found that body dissatisfaction was a risk factor linked to negative affect and eating pathology. An elevated body mass was found to be a risk factor contributing to the perceived social pressure to be thin, body dissatisfaction and dieting.

Furthermore, social modeling of an ideal body image as well as the modeling of eating disturbances was found to contribute to the development of bulimia nervosa. Given the risk factors implicated in the development of an eating disorder, it is concerning that approximately 15% of children and teens between the ages of 6–19 are overweight, while 60% of female and 29% of male high school students reported trying to loose weight and between 20 to 56% of girls and 31 to 39% of boys between the ages of 6–11 were on a diet in 2003 (Haines & Neumark-Sztainer, 2006).

Studies have found that neonatal complications such as premature birth, maternal anemia, diabetes mellitus, preeclampsia, placental infarction, neonatal cardiac problems, hyporeactivity and cephalhematoma to be associated with the development of an eating disorder later in life (Jacobi et al, 2004; Striegel-Moore & Bulik, 2007). Some authors have proposed the possibility that minor brain damage at birth may cause feeding difficulties in children, later leading to severe dietary restriction in teenage/adulthood (Striegel-Moore & Bulik, 2007). In addition, the literature review of risk factors conducted by Jacobi et al. (2004) found that perfectionism and

high levels of exercising were predictive of the development of anorexia nervosa, while negative self evaluation was found to be a risk factor for both anorexia and bulimia.

According to Haines & Neumark-Sztainer (2006), childhood teasing has been proposed as a risk factor for the development of eating disorder behaviors. Studies have demonstrated that overweight children who experienced teasing were two times as likely to engage in binge eating behaviors in comparison to individuals who were not teased. Furthermore, in retrospective studies with adult women, teasing was linked to higher levels of restrictive behaviors. However, the authors do offer contradictory evidence for teasing as well. In fact, Stice (2002) did not include teasing as a relevant risk factor due to lack of empirical support.

Family functioning and child rearing have also been the focus of risk factor studies. For example, families who place an emphasis on physical appearance and dieting, along with an overbearing mother, the absence of a father, lack of intimate relationships, conflict avoidance and the outward appearance of functionality have been linked with a greater risk of negative self evaluation and the development of an eating disorder (Mangweth, Hausmann, Danzl, Walch, Rupp, Biebl, Hudson & Pope Jr., 2005). Furthermore, the structure of the family unit of anorexic individuals have been found to be enmeshed, with high expectations of their children, while providing little support during adolescence in terms of separation and individuation (Rehavia-Hanauer, 2003). Women with eating disorders have reported 'nudity as a familial taboo', 'sexuality not discussed in the family', the family rule of 'having to finish all of the food on a plate' and less parental bodily caresses than healthy controls or individuals with polysubstance dependence. In addition, eating disorders have been associated with auto-aggressive behavior and poor eating habits in childhood (Mangweth et al., 2005).

Childhood abuse has been implicated as a risk factor, leading to the development of an eating disorder (Mangweth et al., 2005). It has been hypothesized that abuse can cause unbearable emotions and damages one's sense of identity. Eating disorders may then serve as a style of coping, an attempt to regulate negative affect. Furthermore, victims of abuse often perceive that they have little control over their lives, which may lead to restrictive behaviors in order to regain control. A study by Rayworth, Wise and Harlow (2004) found that the development of an eating disorder was correlated to childhood physical abuse alone, but not sexual abuse alone, while the strongest correlation was when an individual experienced both physical and sexual abuse. Similarly, Mangweth et al. (2005) found that women who developed either an eating disorder or polysubstance abuse were equally as likely to have experienced childhood abuse, suggesting that abuse may be a general risk factor for the development of a mental illness.

A distorted body image is assumed to be one of the underlying cognitive factors to the development of an eating disorder. However, Jansen, Smeets, Martijn & Nederkoorn, (2006) describe several studies that have demonstrated that some women with eating disorders overestimate their body size, while others do not. They point out that normal female controls also tend to overestimate their body size as well, particularly if they are small in stature. These findings inspired Jansen et al. to conduct a study where they recruited normal weight women with and without eating pathology from the general population in the Netherlands who were willing to be photographed in neutral colored undergarments from the neck down. Before the pictures were taken, each subject was asked to rate themselves on a scale of 1–100 in terms of the overall attractiveness of their bodies, the most and least attractive body parts, and how important appearance is to them. The subjects also completed standardized testing to measure levels of eating pathology, depression and self-esteem. Once

the pictures were taken, they were rated for attractiveness by two separate panels, also recruited from the community, consisting of both men and women. The main findings were as follows: The subjects who exhibited eating pathology had a more realistic body image in comparison to the normal controls. Both panels consistently agreed with the eating symptomatic group about which body parts were the least attractive in the photographs. Both panels also found the eating symptomatic bodies to be less attractive than the controls, which corresponded to the ratings given by the subjects themselves. Furthermore, the control group consistently rated their bodies higher in attractiveness than both panels. Jansen et al. suggest that their findings may reflect the lack of a self-serving bias in individuals with eating disorders. This is similar to the depressive realism model of depression, which states that "depressed people are often more accurate and less biased in their perceptions and judgments than non-depressed people, and that just the normal subjects are prone to making biased and distorted judgments in a self-enhancing direction" (p. 133). However, the authors point out that the eating symptomatic group was found to be significantly more depressed than the controls, which may have contributed to the above findings.

There are several proposed sociocultural theories, which emphasize the environmental aspect of developing an eating disorder. These models tend to emphasize the dominant culture's ideal of the female body, which has become increasingly and unrealistically thin. These models argue that when women are exposed to a thin ideal they internalize this ideal. Once this occurs, the person begins to compare herself to the cultural ideal making her likely to experience a discrepancy between the self and the ideal. This may in turn lead to body dissatisfaction, dietary restraint and/or compensatory behaviors, such as purging or laxative abuse (Striegel-Moore & Bulik, 2007). These theories are concerning since it is estimated that the average youth spends 6.5 hours per day watching television or videos, using print media, playing with

videogames, using computers and listening to music (Haines & Neumark-Sztainer, 2006). Furthermore, according to Kiang & Harter (2006), in 1992 advertisements and articles related to body shape and weight loss are 10 times more likely to be in a women's rather than a male magazine. The authors point out that this statistic corresponds to the 10:1 prevalence of eating disorders in females in comparison to males.

Perceived pressure to be thin, which may occur due to sociocultural values as well as in relation to sports activities, such as ballet and gymnastics, has been shown to increase the likelihood of body dissatisfaction, dieting behaviors and negative affect (Stice, 2002). Furthermore, perceived pressure to be thin was demonstrated to predict binge eating and bulimic symptoms in a longitudinal study by Stice, Presnell and Spangler (2002). Similarly, a meta-analysis by Groesz, Levine & Murnen (2002), revealed that exposure to images of the thin ideal resulted in the instant rise of body dissatisfaction. This effect seems to increase for women who were initially experiencing body dissatisfaction before media exposure, perhaps due to the fact that individuals who are already dissatisfied with their bodies are more likely to engage in social comparison processes (Stice, 2002). This finding is troubling when one considers that 50% of girls and 30% of boys report they are dissatisfied with their bodies (Haines & Neumark-Sztainer, 2006).

Pine (2001) conducted research that examined the link between body image and perceived femininity in children ages 5 to 11. Both male and female subjects were asked to rate a drawings of figures that ranged from very thin to very fat in terms of the "nicest shape", and which they would "like to look like when [they] grow up?" (p. 525). The children also rated the figures on personality traits and potential hobbies the hypothetical person may include in his/her life. Each series of drawings included a number scale from 1 to 9 under each figure, 1 being very thin and 9 being very

fat. Numbers 4 and 5 subjectively correlate to a muscular male or a female figure with moderate breast size and hips. The results were as follows: By the age of 11, both the girls and boys chose the same ideal male body figure, which corresponded to the number rating of 5, the most muscular picture of the male figures. However, the girls chose thinner ideals than the boys for the model female form; the girls chose a 3, where as the boys chose a 4.

In the Pine (2001) study, 11-year-old boys stated that they would like to grow up to look most like a 4.5, where as their female counterparts stated that they would like to look most like a 3. In addition, stereotypically female traits as defined by Pine were associated with the thinner female pictures than the larger ones, such as "likes home, draws & paints, is kind, is helpful, likes children and likes to sing" (p. 531). In contrast, stereotypically male traits such as "likes to win, adventures, to be leader, to fix and mend, likes job/work and to be strong" (p. 531) were not found to be associated with any particular body type. This suggests that stereotypical male gender roles are not associated with body shape at the age of 11. Furthermore, Pine found that 83% of 11-year-old girls knew someone else that was dieting, while 61% reported that their mothers had dieted, while 72% of girls stated they would go on a diet themselves, in contrast to 41% of boys. When one bear in minds that social modeling has been proposed to contribute to the development of an eating disorder, these findings may become a cause for concern (Bruch, 1974; Striegel-Moore & Bulik, 2007).

In contrast to the above sociocultural research, Cash, Morrow, Hrabosky & Perry (2004) conducted an 18-year longitudinal study from 1983 to 2001 in order to measure changes in body image at a mid-Atlantic American university. Interestingly, they found that among Caucasian women, body image evaluations worsened in the 1980s and mid 1990s, but then began improving in the late 1990s and early 2000s

despite the fact that the average body mass has been increasing. The authors propose that perhaps "the growing public consciousness of body image as an issue, the perils of dieting and eating disorders, and efforts to enhance cultural media literacy may empower females and promote body acceptance" (p. 1087).

Genetic risk factors have also been identified for eating disorders. Reflecting upon the genetic aspects of eating disorders helps fill in the blanks in spaces that socio-cultural theories have not provided adequate answers to. For example, if all women are exposed to the dominant culture's ideal of the female body why are some women more resilient than others and do not develop an eating disorder? Striegel-Moore & Bulik (2007) describe the proposed Gene x Environment model relating to the genetic risks for developing an eating disorder. For example,

> An individual with Genotype A might experiment with her first extreme diet, find the experience aversive and uncomfortable, and reject the behavior on the basis of it not being at all reinforcing. In contrast, an individual with Genotype B might experience that first episode of sever caloric restriction to be highly reinforcing by reducing her innate dysphoria and anxiety, providing her with a sense of control over her own body weight and resulting in her receiving positive social attention for weight-loss attempts. (p. 188)

Another possibility is that genetic main effects will be found for eating disorders, such as genetic markers that relate to eating disorder behavior. In support of this, twin studies estimate that the hereditability of anorexia nervosa is between 48–76%, while the hereditability of bulimia nervosa has been estimated to be between 50–83%. One population based twin study conducted in Norway estimated the hereditability of binge eating disorder to be 41%. Furthermore, follow up studies have shown that even when a formerly diagnosed anorectic is no longer meeting the diagnostic criteria

for an eating disorder, these individuals tend to maintain a low body weight and continue to demonstrate character traits such as perfectionism and cognitive restraint (Striegel-Moore & Bulik, 2007).

Understanding genetics contributes to our understanding of how biology can effect how an individual reacts to the environment. For example, studies have found genes that can make someone more susceptible to variable or unstable environments. One such gene is MAOA, which is considered a variant gene, a gene that can alter another gene's expression. One study found that low levels of MAOA expression was significantly correlated with a child developing behavior problems after experiencing abuse early in life (Caspi, McClay, Moffitt, Mill & Craig, 2002; Striegel-Moore & Bulik, 2007) Another study found that individuals with low expression of the variant gene SLC6A4 are more likely to exhibit the symptoms of depression and suicidality after experiencing stressful life events (Caspi, Sugden, Moffitt, Taylor, Craig & Harrington, 2003; Striegel-Moore & Bulik, 2007).

Treatment of Anorexia Nervosa

Stein, Saelens, Zoler Dounchis, Lewezyk, Swenson & Wilfley (2001) reviewed nine studies regarding outpatient treatments and anorexia nervosa, where the average treatment length was between one and two years. They caution that due to the small number of studies as well as methodological errors, replication of the following results are needed. In terms of family therapy, the authors point out that only the Maudsley approach has been empirically tested using controlled studies. The Maudsley model of anorexia proposes that "individual, family and sociocultural influences interact to maintain the disorder" (p. 698), where there are three phases of therapy that are managed over an 8 to 14 month period, for a total of 15 sessions. The first phase involves meeting with the family in order to raise awareness of the seriousness of

anorexia and to encourage the family to "take complete control of their daughter's eating" (p. 698). When the patient gains a satisfactory amount of weight, the second phase begins, where the patient is then encouraged to take responsibility for her own eating and family issues beyond the dinner table are discussed. The third phase occurs when the risk of patient relapse has been minimized. Here, the sessions involve promoting appropriate family roles and boundaries. According to Stein et al., findings have indicated that the Maudsley model is more effective with individuals with early onset anorexia (less than 18 years of age). These subjects had a good or intermediate outcome five years after family therapy treatment.

Stein et al. (2001) also review cognitive behavioral treatment (CBT) for anorexia nervosa. They describe the CBT technique as a three-stage model, where the first phase involves psychoeducation regarding anorexia along with self-monitoring and structured techniques for altering food intake. During this phase, there is an emphasis on building a therapeutic relationship and increasing motivation for treatment. For example, aiding the patient to come to his or her own conclusions and making a list of the pros and cons of anorexia are some of the techniques employed by a CBT therapist. The middle stage involves CBT techniques that aid the patient to "operationalize, examine evidence for, and empirically test specific beliefs... these techniques are supplemented with an explicit focus on having patients examine whether the behaviors that follow the beliefs are adaptive" (p. 700). The last phase focuses on relapse prevention and termination issues. Some CBT approaches will also focus upon interpersonal factors as well as family relationships. Stein et al. discuss two controlled studies of CBT, where the weight of the anorectic subjects improved. The authors also discuss a preliminary study regarding CBT in comparison and in combination with pharmacological treatment. Here, the results indicated that many individuals with anorexia are unwilling to accept pharmacology alone, but when combined with

CBT there is a greater improvement in self-esteem than CBT alone.

In a literature review by Bulik, Berkman, Brownley, Sedway & Lohr (2007), the authors examine 19 studies regarding the efficacy of treatments for anorexia nervosa. They conclude that medications alone or medications used in conjunction with behavioral interventions, such as CBT, cognitive analytic therapy (a method that blends psychodynamic and behavioral approaches), and family therapy have been demonstrated to have weak results with both adolescents and adults. Furthermore, behavioral interventions alone were interpreted as having weak results for adults, but moderate results for adolescents. Bulik et al. state that generalized conclusions should not be drawn from these studies due lack of statistical rigor, small sample sizes and no consensus in the definitions of the stages of illness for anorexia nervosa such as remission, recovery or relapse. In terms of outpatient treatment, Stein et al. (2001) point out that the American Psychiatric Association provide practice guidelines for working with individuals diagnosed with anorexia nervosa. The authors suggest that patients should be regularly referred for medical evaluations, due to the risk of medical complications associated with anorexia nervosa. Furthermore, therapists may need to collaborate with a nutritionist as well as experts in other disciplines in order to ensure proper progress and monitoring is taking place. Another important factor when treating a patient with anorexia on an outpatient basis is knowing when to refer the patient for intensive outpatient or inpatient treatment. Some indicators include when a patient is under 75% of one's normal body mass, when there is a low motivation to recover, and/or when there is a large amount of environmental stress.

Treatment of Bulimia Nervosa

CBT protocol for the outpatient treatment of bulimia nervosa often includes 18 to 20 sessions and three treatment phases. The first phase involves psychoeducation

of the patient regarding bulimia and symptom maintenance in order to help open a dialogue regarding the patient's experience with the illness, while support is offered as the patient regularizes her eating patterns by reducing instances of binge eating. In the second stage of treatment, distorted thinking regarding the binge-purge cycle is challenged using both cognitive and behavioral strategies, while the ending stage focuses upon relapse prevention.

In support of the CBT paradigm, a study by Mauler et al. (2006) demonstrated how the emotional responses to food cues seem to differ between women with bulimia and normal controls. When compensatory behaviors are prevented after eating, bulimic women reported negative affect, anxiety, fear of gaining weight, tenseness, irritation and depression. In contrast, control groups of non-bulimic women tend to describe food cues as reinforcing and appetitive. The authors found in their study comparing the physical and emotional reactions of bulimic and non-bulimic subjects to food cues that bulimic subjects who were deprived of food for a 24-hour period were more likely to binge eat at a buffet and have more subsequent negative physical and emotional responses than bulimic subjects not deprived of food, normal subjects deprived of food and normal subjects not deprived of food. Therefore, Mauler et al. suggest that binge eating may be intensified when a person attempts to restrict their dietary intake. That is to say, limiting one's dietary intake seems to be one component of a vicious cycle of restricting, binge eating and compensatory behaviors. Interpersonal therapy (IPT) proposes a theory of bulimia nervosa that focuses specifically on interpersonal functioning. Bulimia nervosa is associated with poor interpersonal functioning and social adjustment. For example, bulimics are more likely to have destructive sexual relationships, are more likely to have difficulties with impulse control, as well as having personality disorders (Sadock & Sadock, 2003). According to Stein et al. (2001),

> IPT focuses on altering interpersonal situations and improving current interpersonal roles. IPT for bulimia nervosa helps clients identify the link between disordered eating and current interpersonal problems, ultimately leading to improvements in binge eating, compensatory behavior, and attitudes toward eating, shape and weight. (p. 706)

IPT treatment often also takes place over 15 to 20 sessions and includes three stages of treatment. However, the focus of each phase differs from CBT. In the beginning phase, the patient identifies the most problematic area of interpersonal functioning. The middle phase is marked by actively working to change and improve the targeted problem. Lastly, therapy focuses upon termination and review of therapeutic work (Stein et al, 2001).

Most individuals diagnosed with bulimia do not require inpatient treatment unless comorbid symptoms such as suicidality or substance abuse are present. Since bulimics tend to experience their symptoms as ego dystonic, they may be more likely to seek treatment in comparison to anorexics, although therapy may be "stormy and prolonged" (Sadock & Sadock, 2003, p. 749). Stein et al. (2001) review literature regarding the treatment efficacy of CBT and IPT for bulimia nervosa. The authors note that CBT is widely tested and has considerable evidence supporting the efficacy of this approach. In addition, Stein et al. point out that IPT is similar to CBT in terms of short and long-term outcomes. Furthermore, this source related severity of binge eating and purging, history of substance use disorders, low body weight, low self esteem and the presence of a comorbid personality disorder and/or Axis I disorder as predictors of poor treatment outcomes with those diagnosed with bulimia nervosa. For example, individuals who show less than a 70% decrease in purging frequency by week four are 25% less likely to abstain from purging by the end of treatment.

A literature review by Shapiro, Berkman, Brownley, Sedway, Lohr & Bulik (2007)

reviewed the treatment efficacy for bulimia nervosa based on the results of 37 randomized controlled trials. Medication alone and medication used in conjunction with behavioral interventions were found to have strong treatment outcomes. The medications included in this review where second generation antidepressants, tricyclic antidepressants, MAOIs, an anticonvulsant and a 5HT3 antagonist. Similarly, behavioral interventions, such as cognitive behavioral therapy and dialectical behavioral therapy were found to have strong treatment outcomes. In contrast, self help interventions, such as using a self help book, both with and without a facilitator, was found to have a weak treatment outcome. In their discussion, Shapiro et al. call for more analytical rigor and caution that the statistical analyses offered in the reviewed studies would not considered to be efficacious. Furthermore, they discuss the fact that most studies with bulimia nervosa have high dropout rates, making the statistics less effective.

Treatment of Binge Eating Disorder

According to Stein et al. (2001), the CBT model of binge eating disorder is similar to that of bulimia nervosa. This model includes low self-esteem, negative affect and concerns about weight/shape as prompts for a binge eating episode. However, as stated previously, individuals with binge eating disorder do not exhibit the dietary restraint or compensatory behaviors that are indicative of bulimia nervosa. Rather, patients tend to demonstrate a chaotic eating pattern. Therefore CBT proposes that by altering the eating pattern, promoting average caloric intake and targeting dysfunctional thoughts, the binge eating cycle will be reduced until it is eventually alleviated. IPT models have also been proposed for binge eating disorder. Similar to their conceptualization of bulimia nervosa, IPT posits that maladaptive interpersonal relationships are at the root of binge eating disorder. However the treatment strategy is modified to include the examination of the impact of obesity on the patient's

personal relationships as well as difficulty forming meaningful relationships, which is more common among binge eaters than bulimics.

Stein et al. (2001) point out that there is little weight change that is associated with both psychological and pharmacological treatments of binge eating disorder. Therefore, behavioral weight loss treatment (BWLT) has been proposed to treat this disorder. BWLT adjusts caloric intake to a low calorie diet, between 1200 and 1500 calories per day or a very low calorie diet, less than 1000 calories per day, while aiding patients to increase their physical activity. It is proposed that by decreasing irregular and chaotic patterns of eating, BWLT aids individuals to cease the binge-eating cycle. While BWLT has a greater impact on initial weight loss in comparison to CBT and IPT, this change in weight was not shown to be fully maintained in the long term, although after a one year period the average patient had lost 13 pounds. In contrast, individuals who received CBT treatment maintained a stable weight after one year, although their weight was the same as it had been before they sought treatment. This contradicts previously mentioned research by Mauler et al. (2006) who propose that binge eating may be intensified when a person attempts to restrict his or her dietary intake (see subsection Treatment of Bulimia Nervosa).

In a literature review by Brownley et al. (2007), the authors investigated the treatment efficacy of binge eating disorder as seen through 20 randomized controlled trials. Medication alone and a combination of medication and behavioral intervention were found to have moderate treatment results. Similarly, behavioral, cognitive behavioral and dialectical behavioral therapy demonstrated moderate outcomes as well. Self-help interventions, such as self help books, used both with and without a facilitator had a weak treatment outcome. However, in their discussion, Brownley et al. call for more analytical rigor and cautioned that the statistical analyses offered in the reviewed studies would not be considered efficacious.

Developmental Issues

As stated previously, psychodynamic theories suggest that difficulties surrounding early nurturance (the oral phase), and the separation and individuation phase (the anal phase) underlie the psyches of individuals who suffer from anorexia. Furthermore, family issues have also been identified as underlying the development of an eating disorder, which would correspond to the phallic phase, where the oedipal takes place (Lubbers, 1991; Sadock & Sadock, 2003). In her writings, Levick (1983) relates the psychosexual stages of development to the stages of cognitive growth proposed by Piaget. She believed that an individual's defensive processes are characterized by how he organizes the reality of his world as exhibited through developmental stages. Thus Levick implies that if individuals with eating disorders are continually trying to resolve the developmental phases of early life, they would also exhibit cognitive patterns that correspond to these stages. For example, the oral, anal phases and phallic phases correspond to Piaget's sensorimotor and preoperational stages of thought. The sensorimotor period occurs between birth and age two. It is characterized by object permanence, egocentrism and symbolization, meaning that expression primarily occurs through mental symbols. The preoperational period takes place between the ages of two and seven. This stage is characterized by thinking and reasoning that is intuitive, along with a "sense of 'immanent justice'- punishment for bad deeds is unavoidable", "egocentrism", "'phenomenalistic causality'- events that occur together are thought to cause one another", and "'animistic thinking'- physical events and objects are endowed with feelings and intentions" (Sadock & Sadock, 2003, p. 28). Indeed, research suggests that the cognitions of eating disorder patients correspond to Piaget's sensorimotor and preoperational stages of thought. For example, phenomenalistic causality is considered a form a magical thinking (Sadock & Sadock, 2003), which is common amongst both anorexics and bulimics (Levens, 1995). This

is further demonstrated by the psychodynamic theory of bulimia, where the concept that nurturance and eating represent a wish to fuse with the caretaker, while purging symbolically represents an unconscious wish for separation (Sadock & Sadock, 2003). In addition, the concept of immanent justice may be observed by statements such as the intrusive thoughts of anorectic subjects reported by Lavender et al. (2006), "I'm fat and should be punished" (p. 338).

In support of the above notion, Pine (2001) conducted a study (see the subsection entitled Risk Factors of Eating Disorders) that examined the ideal and aspired to body shape of children between the ages of 5 and 11. Interestingly, one finding demonstrated that when 5-year-old girls were asked to choose from scaled pictorial images from 1 to 9 (very thin to very fat), their ideal figures were found to be approximately 1.25 and their aspired to body type to be 1.75. The author correlates this result with theories that propose that anorectics do not develop formal operational thinking, the last stage of Piaget's theory of cognitive development, "in this sense, their rigid interpretation of body stereotypes is not unlike that of the 5-year-olds in this study, which provides some insight, albeit tentative, into the cognitions underlying anorexia nervosa" (p. 533).

Attachment

Bowlby is the creator of attachment theory, which posits that an individual's interactions with early life caregivers leads to systematic differences in the way the individual copes with distress/threat related cues through out life. Distress cues are perceived by an individual to jeopardize their safety or well-being (Cole-Detke & Kobak, 1996). He posits that there are three main styles of attachment that are formed from early life experience. Secure attachment, anxious avoidant attachment and anxious resistant attachment. Secure attachment develops from an available and

responsive caregiver, where the child is able to develop a mental representation of the caregiver to comfort them in their absence (Newman & Newman, 2003). Secure attachment results in the individual interpreting distress cues as a signal to seek comfort and support from others as a way of coping with stressful life events (Cole-Detke & Kobak, 1996). Secure attachment has also been correlated with successful interpersonal relationships, self-esteem, autonomy and overall healthy functioning (Kiang & Harter, 2006). Other attachment styles form as a defensive strategy when caregivers are perceived as unavailable or unresponsive. For example, anxious avoidant attachment results when the caregiver is perceived as ignoring or rejecting, which results in the attachment system being deactivated. The child then initiates avoidant behaviors in order to minimize the distress cue. According to the Adult Attachment Inventory (AAI), this style of attachment results in distressing childhood memories. In addition, when a caregiver is perceived as inconsistently responsive, the tendency is for the attachment system to be over activated, causing anxious resistant attachment. These children tend to hyper monitor the attachment figure, causing the individual to exaggerate attachment related cues. An anxious resistant style is associated with passive or angry preoccupation with attachment memories in the AAI (Cole-Detke & Kobak, 1996). Interpersonal distrust seems to occur when individuals with defensive styles of attachment are faced with distress cues (Kiang & Harter, 2006). This may result in either the denial or amplification of distress cues along with maladaptive and prolonged efforts to obtain comfort, depending on the type of attachment the individual developed early in life (Cole-Detke & Kobak, 1996).

Eating disorders seem to be associated with the anxious avoidant subtype since the inability to discriminate one's inner emotions or distress cues is common amongst this population (Cole-Detke & Kobak, 1996; Kiang & Harter, 2006). Furthermore, the focus on one's appearance may redirect one's attention from the attachment fig-

ure. Defensively, this may occur because changes in one's body may be regarded as obtainable, while a supportive relationship is perceived as out of reach. In contrast, depressive symptoms have been correlated with the anxious resistant style of attachment, where distress cues may cause excessive rumination in these individuals as a coping strategy (Cole-Detke & Kobak, 1996). The question of why there is a high comorbidity rate between eating disorders and depression has yet to be adequately addressed through attachment theory.

Late Onset Eating Disorders: Middle Aged and Mature Adults

According to Hall & Driscoll (1993), the earliest report of late onset anorexia was made in 1976 by Kellett, Trimble & Throley, who sighted a 52-year-old female. This was followed by a case report of a 70-year-old female with late onset anorexia by Lauder (1978). Bodily changes associated with aging are proposed to have a negative effect on body image (Lewis & Cachelin, 2001), which is a risk factor for the development of eating disorders (Stice, 2002).

According to Lewis & Cachelin (2001), body image disturbances, drive for thinness and eating disorders remain under diagnosed in the middle aged and mature populations. For example, studies comparing college aged women with middle aged women (40–65 years old) have found that body dissatisfaction is relevant to both groups. Furthermore, Harris & Cumella (2006) point out that they have seen a 400% increase in midlife eating disorder patients over the past 10 years in their treatment facility. This is a staggering statistic when one considers that for many years eating disorders were not thought to exist past the age of 35. One must remember that, "healthy aging does not include depression, hopelessness, and food refusal. These phenomena are pathological and can be remediated at any age" (p. 25).

Similar to their younger counterparts, severe or adverse life events may be a risk

factor for the development of a late onset eating disorder (Schmidt, Troop & Treasure, 1997). Harris & Cumella (2006) discuss common triggers to the onset of an eating disorder in middle age. For example, the death or illness of a parent may bring issues of maturity and independence to the forefront, where an eating disorder may allow the individual to remain dependent on others. The death of a peer or sibling may raise the issue of one's own mortality, causing an individual to seek a youth like appearance through over exercising and dieting behaviors. The loss of a child may lead to despair and passive suicidal ideation that may be sought through self-starvation. Enduring a physical illness, such as breast cancer, may deepen body dissatisfaction issues and pose a threat to the acceptance of one's own body. A divorce may bring up issues of dependency, low self-esteem, fears of being alone and being attractive for the dating scene to emerge, causing excessive attention to one's appearance through diet and exercise. Remarriage may also be a risk factor if an individual does not know how to express her needs or emotions in the new family system. This may lead to the act of starving oneself or purging in order to symbolically gain a voice within the family system. In addition, some people may have difficulty accepting the normal aging process, which may damage one's self-esteem and challenge one's identity, causing these individuals to engage in unhealthy weight management to seek what they consider a more youthful appearance. Lastly, many women make their children the central focus of their lives. However, when their children move from their parental homes, a mother may begin questioning her role in the family system and may attempt to fill the void by focusing excessively on diet, exercise and appearance. According to Harris & Cumella (2006), many middle aged women who develop a late onset diagnosis were experiencing subclinical symptoms for years. These women are less likely to engage in severe caloric restriction, although they are more likely than younger women to use over the counter and non-FDA approved

weight loss medications. Furthermore, the health risks associated with long-term semi-starvation parallel those of anorexia nervosa.

Lewis & Cachelin (2001) state that the clinical presentation of eating disorders in the mature adults is similar to adolescents, although it has been suggested the psychological and physical changes associated with aging, such as menopause and weight gain, may parallel the bodily changes during puberty. The authors point out that,

> Concern with aging, the belief that weight loss and a slim physique result in youthful looks, and the increasing social pressures on older women to retain physical attractiveness and sexuality can contribute to the development of disordered eating. (p. 30)

In their study examining differences between 125 middle aged (50 to 65 years) and elderly women (66 years and above), Lewis & Cachelin found that both cohorts were similar to each other in terms of ideal body size and body dissatisfaction. The middle-aged group, in contrast, was found to have a higher drive for thinness on the Eating Disorder Inventory (EDI) than the elderly group. In addition, the authors found that "although equally dissatisfied with their bodies, elderly women are less likely than middle aged women to report doing anything about it, such as restraining their eating or engaging in other weight-related behaviors" (p. 36), although no explanation was offered by the authors as to why this seems to be the case.

Harris & Cumella (2006) discuss the fact that often times an eating disorder in the elderly may be an attempt at exerting control over one's life, since many individuals experience a loss of autonomy as they age, "food refusal can also begin as a form of protest or attention seeking to alert loved ones that they are deeply unhappy about circumstances, restrictions, or lack of visitation from the family" (p. 25).

According to the United States Department of Health and Human Services, the poverty line in 2005 for a single person household was considered to be $9,570 and below. For a two person household the poverty line was set at $12,830 and below. Furthermore, the US census reported that 28% of households including individuals aged 65 and above earned less than $15,000 in 2005. Harris & Cumella (2006) suggest the possiblity that due to financial constraints some elderly individuals may restrict their dietary intake in order to save money. Sometimes dietary restriction may be a passive form of suicide as well. Harris & Cumella (2006) state that body image disturbance may not be present in a late onset eating disorder, in which case, the diagnosis of eating disorder NOS is most appropriate. However, Hall & Driscoll (1993) warn that some reported cases of late onset anorexia may have been better explained as depression with the loss of appetite.

The health risks of eating disorders in a mature population are similar to adolescents, such as osteoporosis and poor cognitive performance. However, one must judge these risks to be especially concerning considering that stress fractures and cognitive impairment are more likely to occur in the elderly population. Furthermore, mortality rates due to low weight have been shown to increase with age (Lewis & Cachelin, 2001). According to Harris & Cumella (2006), 78% of deaths associated with anorexia nervosa occur in individuals over the age of 65.

Men and Eating Disorders: An Overview

The first reported case of an eating disordered male was written by Dr. Richard Morton in 1689 (Carlat et al., 1997). Approximately 300 years later the existence of eating disorders in males has been accepted, although the majority of the psychological community only began acknowledging this as fact in the 1980s. Carlat et al. point out the importance of examining eating disorders in males:

> From a clinical standpoint, there is a need for practical information on males with eating disorders to help guide diagnostic and treatment decisions. From a theoretical standpoint, the study of males with eating disorders contributes useful information to the question of eating disorder etiology. If it is found that men with eating disorders do not differ significantly from their female counterparts, this finding may support a more biologically based view of a discrete and relatively invariant disease entity, like schizophrenia. However, if men with eating disorders are found to share certain cultural or psychological risk factors, then the sociocultural view of eating disorders would gain support (p. 1127)

Overall, it is agreed that the symptom presentation and response to treatment of anorexia nervosa, bulimia nervosa and binge eating disorder in men is similar to their female counterparts (Baum, 2006; Harris & Cumella, 2006, Weltzin, 2007). However, one must note that studies focusing on the eating disordered male tend to have small sample sizes, no control groups, and concentrate on the Caucasian population, making generalization and result interpretation difficult (Bramon-Bosch, Troop & Treasure, 2000; Woodside et al., 2001; Muise et al., 2003; Harris & Cumella, 2006). Eating disorders occur far less often in men than women. According to Muise et al. (2003), between 5-15% of all cases of anorexia and bulimia diagnoses are in males. Interestingly, this type of a gender difference has only been observed in diseases that are directly linked with reproductive functioning or sex chromosomes (Anderson & Holamn, 1997; Braun et al., 1999). In their study, Carlat et al. (1997) found that over 50% of an eating disordered male sample received a poor treatment outcome, which is a similar prognosis as females. Furthermore, Braun et al. (1999) reported that they observed a rise in the admission rate of males to the Cornell Medical Center eating disorder unit between 1984 and 1997, suggesting an increase in eating disorder

diagnoses in men throughout the 1980s and 1990s.

Most researchers agree that the age of onset for eating disorders tends to be later in men than women (Braun et al., 1999). For example, in a study conducted by Bramon-Bosch et al. (2000), which compared an inpatient sample of 30 men to 326 women, the males were found to have a later age of onset than the female group (23.2 years versus 18 years). In addition, Braun et al. (1999) found the mean age of onset of eating disorders in males to be 20.6 years in comparison to women, whose mean age of onset was 17.2 years. The authors propose that since puberty often marks the beginning of dietary restriction in females, males reaching puberty 1.5 to 2 years later than females would affect the age of onset for eating disorders between the sexes.

Several characteristics have been identified in the eating disordered male, which have been summarized by Muise et al. (2003) in a extensive literature review. For example, men with eating disorders have been identified as more likely to be athletes prior to diagnosis, are less concerned with their actual weight but are more concerned with obtaining a masculine shape, and have a higher comorbid diagnosis for psychiatric disorders and substance abuse. According to Harris & Cumella (2006) men are more likely than women to be obese prior to diagnosis, impulsive, obsessional, and often engage in over-exercising behavior in order to gain a more muscular physique rather than a thinner body. Anderson & Holamn 1997, discuss that males reach a significantly higher BMI than females do before they begin dieting. In addition, men who strive for a muscular shape tend to be displeased if they lose weight, suggesting a possible subtype of muscle dysmorphia, which would currently fall under the diagnosis of eating disorder NOS. These findings suggest that disordered eating may be difficult to detect amongst men who are not underweight (O'Dea & Abraham, 2002). Lastly, gender identity issues and homosexuality are also considered risk factors for the development of an eating disorder in men (Harris & Cumella, 2006; Weltzin,

2007).

Anorexia Nervosa in Males

The ratio of anorexia nervosa in men in comparison to women is commonly thought to be approximately 10:1, although when partial syndromes are considered this ratio rises to as high as 2:1 (Geist, Heinmaa, Katzman & Stephens, 1999; Woodside et al., 2001). Studies have shown that men with anorexia resemble females in terms of psychiatric comorbidity. Furthermore, Weltzin (2007) describes a study that indicated differences in the effects of starvation on the male brain in comparison to the female brain. The serotonin platelet activity in the male brain was not found to decrease in response to malnutrition, as has been found with women. However, the possible emotional or behavioral consequence of this neurological response was not discussed.

When diagnosing anorexia nervosa in men, one must consider that certain biological markers of the disorder will not be present. This may make the recognition of the signs of starvation somewhat more difficult. For example, men will not present with amenorrhea, criteria number four in the DSM IV TR for the diagnosis of anorexia nervosa (Muise et al., 2003). Baum (2006) points out that "male athletes can far more easily sustain dramatically lower body fat (in the order of 1%) without profound medical sequelae, while female athletes must maintain about 17% body fat to avoid amenorrhoea" (p. 2). Therefore, clinicians must gauge malnourishment through the use of the Body Mass Index (BMI), where males under the 25th percentile should be considered emaciated. In addition, although the main health consequences for anorexic males are similar to that of women, males seem to present with more severe health problems. This may occur as a result of the secrecy associated with anorexia, as well as males being in a more advanced stage of malnutrition than females before family, friends or physicians insist on medical attention (Muise et al., 2003).

Bulimia Nervosa in Males

According to Muise et al. (2003), males are thought to account for 10 to 15% of all cases of bulimia nervosa. The ratio of partial syndrome cases of women versus men have been estimated to be as high as 2.9:1 (Woodside et al., 2001). Men resemble women in terms of clinical presentation, comobidity and medical complications, such as dental enamel erosion and electrolyte disturbances. In their study, Carlat et al. (1997) found that bulimic males tend to seek treatment later than anorexic males, perhaps due to the shame associated with having a stereotypically female disorder. Men who binge eat are significantly less likely to report weight control behaviors such as purging and laxative abuse than women (Braun et al., 1999; Strigel-Moore & Bulik, 2007). When compensatory methods are used, they tend to be for different objectives in comparison women. For example, men may report using compensatory behaviors such as laxative abuse or purging in order to reduce body fat and increase muscularity (Striegel-Moore & Bulik, 2007).

Eating Disorder NOS/Binge Eating Disorder in Males

As stated previously (see the subsection entitled Men and Eating Disorders: An Overview), the prevalence rate of binge eating disorder is estimated to be between 0.7 and 3.0% (Berkman, Lohr & Bulik, 2007). Furthermore, binge eating disorder has been found to be equally as common in men as in women, with similar clinical presentations (Striegel-Moore & Bulik, 2007). According to Weltzin (2007), research suggests that binge eating in men is triggered by anger, whereas anger suppression is linked to binge eating in women.

Risk Factors for Males

Risk factors in men tend to be similar to women, although some differences have been observed. In a literature review by Stice (2002), an elevated body mass was found to be a risk factor contributing to the perceived social pressure to be thin, as well as body dissatisfaction and dieting (see the section entitled Risk Factors of Eating Disorders). Carlat et al. (1997) reported that 60% of their male sample admitted to being overweight before the onset of anorexia, bulimia or eating disorder NOS. Furthermore, social isolation is common amongst eating disorder patients (Sadock & Sadock, 2003). This risk factor may be elevated for males. For example, Bramon-Bosch et al. (2000) found that eating disordered men were less likely than women to have social supports. It was also found that the male cohort tended not to participate in leisure activities before inpatient admission.

According to Bramon-Brosch (2000), men with eating disorders may be more likely to receive a comorbid diagnosis of anxiety or depression and to exhibit suicidal ideation upon admission to inpatient treatment. Similarly, a study conducted by Carlat et al. (1997) reported that the most common comorbid diagnoses across all eating disorders are major depressive and anxiety disorders. In contrast, the literature indicates that women with eating disorders tend to exhibit more self-harming behaviors than men (Bramon-Bosch, 2000) and tend to report higher rates of sexual abuse than men (Woodside et al., 2001).

Carlat et al. (1997) found substance abuse and personality disorders to be a common diagnosis with bulimic men, which is similar to the presentation of bulimia in women (Sadock & Sadock, 2003). In addition, Carlat et al. (1997) found that 61% of the bulimic males studied reported a substance abuse problem. This is higher than the incidence of substance abuse in the general population, indicating that substance abuse is a risk factor for the development of bulimia in men. Homosexuality has

been proposed as a specific risk factor for the development of eating disorders in men (Russell & Keel, 2002). For example, community based studies have suggested that homosexual and bisexual men tend to exhibit higher levels of body dissatisfaction, depression, weight concerns, dietary restraint and compensatory behaviors than heterosexual men (Russel & Keel, 2002; Austin, Ziyadeh, Kahn, Camargo, Colditz & Field, 2004; Kimmel & Mahalik, 2005). In a retrospective study of 133 male eating disorder patients by Carlat et al. (1997), 41% identified themselves as heterosexual, 27% identified as homosexual and 32% considered themselves currently asexual. Of the asexual group, 73% identified as heterosexual, while 27% considered themselves homosexual. The statistics for homosexuality in male eating disordered populations is high in comparison to non-eating disordered subjects. For example, in normative male populations the rate of homosexuality is reported to be between 1 and 6%. Furthermore, it should be noted that similar to females, asexuality was common amongst anorexic males in this study. This may reflect the fact that malnutrition lowers testosterone, which in turn decreases sexual desire. Additionally, Austin et al. (2004) report on the Growing Up Today Study of 2001, a longitudinal study of 10,583 adolescent girls and boys throughout the United States. They found that lesbian and bisexual girls were more satisfied with their bodies and were less concerned about trying to look like celebrities in comparison to heterosexual females. Paradoxically, in comparison to heterosexual males, homosexual/bisexual males were more likely to binge eat or diet in the past year and reported being concerned about trying to look like icons in the media.

Body dissatisfaction has been implicated as a risk factor for both men and women. In 2003, the Youth Risk Behavioral Surveillance System (YRBSS) described that 50% of girls and 30% of boys were dissatisfied with their bodies (Haines & Neumark-Sztainer, 2006). The Growing Up Today Study of 1996, which assessed 16,114 boys

and girls between the ages of 9 and 14 in the United States found that 4.9% of boys and 12% of girls considered themselves to be overweight, but were not according to their BMI (Field, Camargo, Taylor, Berkley, Frazier, Gillman & Colditz, 1999). Furthermore, studies have revealed that during the past three decades, male body dissatisfaction has increased from 15% to 43%, which is comparable to rates of body dissatisfaction among women.

Just as the exposure to unrealistically thin beauty standards in women causes an increase in negative affect and body dissatisfaction, so does the exposure to idealistic muscular standards influence the way men evaluate themselves and their bodies (Goldfield, Blouin & Woodside, 2006). According to Cohane & Pope (2001), prior to the late 1980s, body image was viewed as a female issue. Currently, researchers have demonstrated that men also have body image concerns, including muscle dysmorphia. Where girls may exhibit a preoccupation with thinness at a young age, boys may in turn be concerned with either thinness or muscularity (Cohane & Pope, 2001; Jones, 2004). Paxton et al. (2006) found that both depression and peer weight teasing were unique predictors of body dissatisfaction in teenage boys. Furthermore, it should be noted that levels of body dissatisfaction reported by both eating disordered males and females are similar (Halliwell & Harvey, 2006), which may imply separate pathways leading to analogous conclusions.

Cohane & Pope (2001) conducted a literature review of 17 studies comparing the body image of females and males, mostly using pictorial rating scales (see the subsection entitled Risk Factors of Eating Disorders). The authors concluded that although females tended to display more body dissatisfaction than males,

> A substantial number of boys of all ages were not satisfied with their body proportions. In general girls ideally wanted to be thinner, whereas boys were more variable, with some choosing a thinner ideal image and others

choosing a heavier one. (p. 377)

Furthermore, a study conducted by Pine (2001) examined the perceived body image of girls and boys between the ages of 5 to 11 through the use of pictorial images. These images were associated with numbers ranging from 1 to 9 (very thin to very fat). Both 11-year-old girls and boys selected the number 5 as the ideal male figure, subjectively correlating to a muscular male figure (see section entitled Risk Factors of Eating Disorders). According to a study by Jones (2004), an internalized muscular body ideal emerged as an important factor contributing to body dissatisfaction in an adolescent male sample. This was found in contrast to an adolescent female sample, where appearance conversations and social comparison processes were the surfacing factors affecting female body image, suggesting that social comparison may play a central role with adolescent girls but not with boys. In addition, Halliwell & Harvey (2006) found that body dissatisfaction was correlated to social comparison processes in adolescent males who were overweight in comparison to the normal weight group.

While eating disordered females and some eating disordered males seem to have thin ideals and control their weight through dietary restriction or compensatory behaviors, there are a number of males who have internalized muscular ideals and control their weight through unhealthy exercise and steroid use. Between 28% and 68% of normal weight adolescent males believe they are underweight and want to gain weight and muscle mass (Johnson, McCreary & Mills, 2007). Hallsworth, Wade & Tiggeman (2005) explain,

> In young children (5 to 8-year-olds), while the ideal figure for girls is smaller than their current rating, young boys have an ideal figure that is larger than their current size. In children between the ages of 8 and 11, boys are significantly more likely to think about increasing their muscles and to engage in strategies to achieve this goal than girls. The most

> frequent strategy for weight and body shape change for 12-year-old boys is through exercise rather than dieting. (pp. 453–454)

Paxton, Eisenberg & Neumark-Sztainer (2006) reported that 12.4% of boys admitted to frequently using or thinking about using dietary supplements or steroids to increase muscle mass. Furthermore, studies have found that 85% of male college students desire to be more muscular (Hallsworth et al., 2005). According to Johnson et al. (2007), approximately three million men in North America are using steroids or other illegal muscle enhancing drugs. Baum (2006) suggests that wanting to enhance performance, self-esteem and sexual attractiveness motivates steroid use amongst young men. These statistics are concerning when one considers the health consequences of steroid use, which include premature closure of the epiphyses, high blood pressure, liver tumors, sterility, depression, psychosis and suicidal ideation.

In a retrospective study by Braun et al. (1999), which compared 51 males with 693 female inpatient eating disorder patients, 36.7% of the male sample reported involvement with an athletic sport where weight is considered related to performance. In contrast, 13% of the female sample reported involvement in athletics. The male cohort reported involvement in running, weight lifting, wrestling, as well as team sports such as hockey and football, while the female group reported participating in ballet, soccer, softball and tennis. Indeed, male body builders and wrestlers have been the focus of research regarding an extreme muscular/masculine male body image. According to Hallsworth et al. (2005), male body builders have been found to exhibit higher levels of disordered eating and body image disturbance than non-bodybuilders. Furthermore, Goldfield, Blouin & Woodside (2006) discuss research where male body builders have been found to exhibit higher levels of weight and shape preoccupation, dehydration methods and steroid use, as well as strict dieting, which may predispose this population to binge eating practices and compensatory behaviors. Goldfield

et al. found that 30% of their sample of competitive body builders met the DSM IV criteria for bulimia nervosa at some point in their lives. Interestingly, Davis & Scott-Robinson (2000) found no significant differences between the scores of female anorexics and male body builders in terms of narcissism, ineffectiveness, obsessionality, perfectionism and anhedonia. However, in comparison to the anorexic cohort, the male body builders exhibited higher levels of self worth and body image perception. This may have occurred since exercise is thought to be a protective factor against depression (Hallsworth et al., 2005).

Baum (2006) points out that sports which put pressure on the participant to make a specific weight class, such as rowing, wrestling, martial arts and horse racing, may cause heightened amounts of eating disorder pathology in males. For example, jockeys have admitted to using unusual weight loss practices, such as sitting in heated cars while wearing rubber suits. Male wrestlers have been known to use extreme calorie and fluid restriction, laxative and diuretic abuse, and over exercising behaviors before a match. Furthermore, of the children who compete in these types of sports, the influence of one's family may contribute to the development of eating pathology and extreme weight loss measures. Sansone & Sawyer (2007) discuss a case study of a 5-year-old male wrestler who was pressured by his father, a former wrestler, to lose weight because the child "had only lost one match during the season; by wrestling in a lower weight class for the final tournament, he would be able to avoid a match with the one competitor to whom he had lost during the season" (p. 1). This case was brought to the attention of the coach when the child mentioned that he had visited a sauna the night before and had not eaten for two days. The authors report that in response to what seems to be widespread pressure on children, adolescents and adults to compete in specific weight classes, the National Collegiate Athletic Association has modified their weight control rules to emphasize competition rather than weight

management. The new rules focus on creating a new culture where rapid weight loss and dehydration are no longer encouraged.

Sociocultural Factors Specific to Homosexual Males

According to Tiggeman, Martins Kirkbride (2007) studies indicate that homosexual men are more vulnerable to body dissatisfaction, which may correlate to the high number of homosexual men seeking treatment for eating disorders. The homosexual subculture places a strong emphasis on physical appearance and attractiveness. In comparison to women, homosexual men are in general more concerned with the physical attractiveness of their partners. According to Williamson Hartley (1998), there is now consistent evidence that males frequently strongly associate ego dystonic homosexuality and eating disturbance (at both clinical and subclinical levels) (p.161). In addition, homosexual men score higher than heterosexual men on drive for thinness scales, although Tiggeman et al. found that homosexual and heterosexual males score similarly on drive for muscularity scales. Tiggeman et al. point out that this is a finding that is supported by current research on male body image, and had not been found in earlier research. They suggest that this may be due to changes in Western sociocultural values and media influences where men are targeted with impossibly muscular male forms (see below for further explanation). An example of this change in the male value system is the recently emerged concept the *meterosexual*: the (heterosexual) urban man who has a strong aesthetic and pays particular attention to grooming, appearance, and lifestyle (p. 21).

Sociocultural factors proposed for the development of eating disorders in men tend to focus on homosexuality. For example, according to Austin et al. (2004) there are three proposed mechanisms to explain why homosexual men may be more at risk for eating disorders and body dissatisfaction than their heterosexual counterparts,

> First, studies have found that social norms in gay male communities emphasize thinness and appearance, which may place pressures on community members to strive to achieve unrealistic ideals...Second, studies have also found that gay/bisexual males may be drawn to gender nonconformist ideals more so than are heterosexual males, which may allow them to take on roles and behaviors perceived in society as more feminine... However [studies] that compared gay and heterosexual men did not find identification with stereotypically feminine characteristics to differ between the two groups...Third, gay/bisexual males may experience more pressure to be self-conscious about their appearance and develop greater weight and body shape concerns because, like heterosexual women, they are objects of male sexual attention. (pp. 1120–1121)

Furthermore, the minority stress model has been proposed to explain the high amount of mental health and substance abuse problems found within the gay and lesbian community. The theory postulates that homosexuals are subjected to chronic stress due to expectations of stigmatization, internalized homophobia, and belief in the probability of experiencing prejudicial events, such as violence. Internalized homophobia refers to "the degree to which a gay man internalizes the antigay sentiments of the larger heterosexual society and represents an internal form of stress" (Kimmel & Mahalik, 2005, p. 1185). Kimmel & Mahalik discuss that some researchers have speculated that homosexual men who have internalized homophobic attitudes and who have a greater expectation of stigmatization may have the desire to gain a more muscular physique, which is considered a traditional masculine norm, as a defensive reaction to the dominant society. This research inspired the authors to conduct cross sectional research where 357 homosexual males were surveyed using the Internet in order to study the minority stress model of body image concerns and masculine norms.

In their survey the authors included the Body Image Ideals Questionnaire, the Masculine Body Ideal Distress Scale, the Internalized Homophobia Scale, the Stigma Scale, the Conformity to Masculine Norms Inventory, and a question assessing a history of an antigay physical attack. Indeed, the results indicated that internalized homophobia, stigma and the experience of an antigay physical attack were significantly associated with body image dissatisfaction. Furthermore, conformity to masculine norms were only associated with emotional distress if the subject believed that his body did not meet the physically powerful masculine ideal. In addition, the results of a study by Russell & Keel (2002) indicated that homosexual men reported less comfort with their sexual orientation in comparison to heterosexual men. In this study, homosexuality was also associated with higher eating disordered symptoms, lower self-esteem, less body satisfaction and more depression in comparison to the heterosexual cohort.

Another area of focus in sociocultural research has been the pursuit of muscularity in males. According to Leit, Pope & Gray (1999), between 1980 and 1991 men's fashion magazines have printed more articles discussing men's weight and health concerns. Furthermore, the analysis of male action figures has revealed that toys such as GI Joe have been increasing in muscularity over time, where the muscles of these toys are larger than what is humanly attainable. These findings encouraged Leit et al. to review Playgirl centerfold models from 1973 to 1997 in order to observe changes in body composition deemed attractive in the media over time. The results indicated that muscularity in the male models increased over time, while 14% of the centerfolds had a fat-free mass index that was over 25. The authors suggested that these models "likely attained their body shape through the use of steroids" (p. 92).

Johnson et al. (2007) suggest that the above evidence points to an increasing tendency in the objectification of the male physique. Originally used to explain social processes involving women and the internalization of body ideals, self-objectification

theory has currently been used to explain body image disturbances amongst males concerned with muscularity. Self-objectification refers to a form of self-consciousness where an individual is consistently monitoring his physical appearance. This constant self-monitoring can lead to both body shame and appearance anxiety, which may contribute to the development of depression and eating disorders. Hallsworth et al. (2005) studied a sample of male bodybuilders, competitive weightlifters and first year psychology students in relation to the proposed elements of self-objectification theory. The authors found that body dissatisfaction was associated with self-objectification, both of which were primarily experienced by the bodybuilding cohort. Interestingly, depression was found to occur significantly more often in the control group than the bodybuilding or weightlifting groups, which may have occurred because exercise is thought to be a protective factor against depression.

The way in which men and women interact seems to affect the way men perceive themselves. For example, Johnson et al. (2007) describe a study where men who viewed advertisements that depicted women as "sex objects" subsequently described the desire for a more muscular frame. Furthermore, another study found that when males competed against females in cognitive tasks, the males who did not score as well as in comparison to their female competitors subsequently felt dissatisfied with their level of muscularity. In contrast, Johnson et al. conducted research regarding the effects of exposing both objectified male and female images to a sample of 90 men between the ages of 17 and 28. The authors found that exposure to objectified female images increased the general anxiety and hostility of the male sample. However, no significant changes were observed in the rating of one's body in males who were exposed to both objectified male and female images.

Eating Disorders in Middle Aged/Mature Males

Similar to their female counterparts, eating disorders can also affect men later in life. A retrospective study by Striegel-Moore, Garvin, Dohm & Rosenheck (1997), found that 98 of 466,590 men from 155 Veterans Hospitals across the United States received an eating disorder diagnosis upon discharge in 1996. Of these 98 men, the mean age for anorexia nervosa was 51.72 years (SD = 14.21), for bulimia nervosa the mean age was 45.82 years (SD = 7.44), and for men with eating disorder NOS the mean age was 56.68 years (SD = 16.25). 89.3% of men with eating disorder NOS received a comorbid diagnosis, where as 92% of the anorexic sample and 100% of the bulimic sample were dually diagnosed. A comorbid diagnosis of a mood disorder was the most common (between 30-71%), followed by alcohol abuse and dependence (between 32-59%). Interestingly there was a high comorbidity rate for schizophrenia/psychotic disorders (between 18-36%) as well as an organic mental disorder (between 16-27%).

Morgan & Marsh (2006) describe a case study with a 62-year-old male who had been diagnosed with bulimia at the age of 59. This case illustrates some of the previously discussed risk factors for males, such as a history of obesity before diagnosis as well as comorbid diagnoses (Carlat et al., 1997; Bramon-Brosch, 2000; Stice, 2002; Muise et al., 2003; Harris & Cumella, 2006). It should be noted that although a subclinical presentation is common in the late onset of eating disorders (Harris & Cumella, 2006), this case may also underscore the need for heightened awareness amongst health professionals regarding the presentation of eating disorders in males. According to Morgan & Marsh (2006), the patient reported growing up in an impoverished environment, raised by relatives who underfed him as a child. He described his younger self as depressed, shy, a poor student and constantly craving affection. By his early thirties the patient had reached 245 lbs and was 5'8", classifying him obese according to the BMI. He began restricting his dietary intake and lost 70 lbs,

but by age forty he was again considered obese. The patient then began running and bicycling four hours a day and began to abuse laxatives. His over exercising behavior continued into his fifties, until he suffered two hip fractures from two bicycle accidents over a one-year period. The patient then developed heart problems, for which a pacemaker was inserted. Before his most recent hospitalization, the patient had presented to his primary physician with complaints of nausea, vomiting, abdominal pain and weakness. All the while he was binging and purging, although he did not admit this to his doctor. After numerous medical tests, a family member informed the physician of the patient's binge/purge behavior and the patient was referred for a psychiatric evaluation. Upon hospitalization, the patient's weight was 126 lbs, the lower end of normal according to the BMI. The patient's diagnosis of bulimia was supplemented after psychological testing with recurrent depressive disorder and avoidant/dependant personality disorder. After 13 days of individual CBT treatment the patient was discharged to a partial hospital due to the absence of binge/purge behaviors, increase in insight as well as an improvement of his affective symptoms. Morgan & Marsh note that the patient's numerous unexplained medical problems involving the gastric system, as well as the heart and sports injuries may be an indicator of a late onset eating disorder.

An Overview of Art Therapy

The American Art Therapy Association (AATA) defines art therapy as follows:

> Art therapy is an established mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills,

> manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight. Art therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with models of counseling and psychotherapy (http://www.arttherapy.org).

Primarily established within a psychodynamic framework, art therapy has also been influenced by other theories, such as Jungian psychology, guiding the therapist in the understanding and conceptualization of the art making process, its symbolism and underlying dynamics. For example, dreams, which Freud called the *royal road to the unconscious* (Brenner, 1974) are considered "the primary method of unconscious projection [where] man deals with pictorial images" (Naumberg, 1987, p. 44). Jung often encouraged his patients to paint their dreams in order to explore the symbolic language of the psyche, which includes the collective unconscious (Jacobi, 1973; Naumberg, 1987). Furthermore, just as a psychoanalyst would explore the manifest and latent content of dreams, so would the art therapist explore the manifest and latent content in artwork through the careful investigation of form and content, "By form is meant the manner in which images are drawn. In general, form pertains to the manifest picture. Content refers to the images contained in the manifest drawing and also the latent meaning conveyed in the picture" (Cronin & Werblowsky, 1979).

In her book *Art Psychotherapy*, Harriet Wadeson (1980) discusses the unique advantages of using art therapy, although she acknowledges that art therapy is difficult to qualify. For example, what one extracts from a first time art therapy experience will be unique depending on the needs of the observer. Wadeson describes six factors that contribute to the therapeutic experience of art making. Firstly, she points out that art making involves the use of imagery, which is one of the primary modes of cognitive experiencing: "We think in images. We thought in image before we had

words. We could recognize mother before we could say 'mama'" (p. 8). Furthermore, according to the psychodynamic model, primary process thought (both conscious and unconscious) is expressed mostly in images. In contrast to verbal therapies, art therapy has the advantage of allowing primary process thought to emerge directly without having to translate the original image into words. This suggests that the individual's defense mechanisms activated through the verbal expression of primary process material may be bypassed, allowing repressed materials to be accessed more readily (Naumburg, 1987). As Wadeson (1980) describes,

> Art is a less customary communicative vehicle for most people and therefore less amenable to control. Unexpected things may burst forth in a picture or sculpture, sometimes totally contrary to the intentions of its creator. This is one of the most exciting potentialities in art therapy. (p. 9)

The process of art making, which bypasses the defenses may compel the individual to produce new images, leading to flexibility and the use of the creative process in the creation of solutions. Furthermore, it should be noted that artistic ability or skill are not required for self-exploration through art. In fact, Wadeson notes that individuals who are skilled artists are less likely to have *slips of the brush*, which may inhibit spontaneous and less defended artistic creations.

Another advantage of art therapy is what Wadeson (1980) calls *objectification*. That is to say, inherent in the art making process is the creation of a tangible object that may be looked at, reflected upon or modified at any point in time. Artwork may be used to examine similar patterns present within various art pieces. In addition, artwork may be discussed in relation to new art pieces and new ways of relating to the world. Many individuals find it less threatening to relate to the art product than to themselves, especially when unconscious material surfaces in the artwork. The

artwork may act as a bridge between the self and the repressed emotion, thought or fantasy. For example,

> A hospitalized depressed man initially spoke of the angry expression on the face in his picture. He hadn't intended it to look that way and didn't understand why it had come out like that because he did not feel angry himself, he said. Eventually he came to identify with the figure in this picture and recognized his own anger. (p. 10)

Wadeson (1980) also discusses the *spatial matrix*, the nature of art itself being devoid of logic, grammar, syntax and time, as an advantage of art therapy. That is to say, art is not linear but rather spatial in nature, which sometimes is the most precise way of relating an experience. For example,

> If I were to tell you about my family, I would tell you about my mother, *then* about my father, *then* about their relationship to each other, *then* about my brother and his relationship to each of them, *then* about each one's relationship to me. Obviously, I experience all of this at once. And in a picture I can portray it all at once. (p. 11)

Lastly, Wadeson (1980) discusses the physical effect that art making seems to have on the creator. Art making seems to energize the individual, putting the creator in a state of alertness, vitality, and sometimes even playfulness, although the subject matter of the artwork may be dark, solemn or painful. In comparison to verbal discussions, both in group and individual work, Wadeson notes a heightened energy level observed in both normative and client populations when they are creating artwork.

Art Therapy and Eating Disorders

In recent years, a multidisciplinary approach that includes art therapy has been incorporated into the treatment milieu of eating disorders. According to a survey conducted by Frisch, Franko & Herzog (2006) of 19 eating disorder treatment facilities throughout North America, 26.32% of these organizations offer a creative arts therapy group, consisting of either art, dance or music therapy, once per day. The average amount of time per week dedicated to art therapy was 4.5 hours. The average participation rate was found to be 99.21% for anorexic or bulimic patients and 90.55% for patients diagnosed with binge eating disorder.

As stated by Wadeson (1980) in the previous subsection, art therapy allows for personal expression without using words, which helps bypass an individual's defense mechanisms. This may be especially relevant to eating disorder treatment as many individuals with eating disorders have difficulty expressing themselves verbally (Mitchell, 1980; Rehavia-Hanauer, 2003). According to Levens (1990) eating disorder patients may be able to manipulate their vocabulary to avoid the issues at hand. Furthermore, anorexics in particular are known to be especially resistant to treatment. Mitchell (1980) quotes Dally (1969) in saying,

> Some [anorexics] decide to gain weight to demonstrate that all is well–that they no longer need treatment, and that they have worked through their difficult problems themselves. And yet, often they were seen in treatment again within a few months, more lost in the illness than before. (p. 54)

Art therapy, therefore, may address the client's resistance directly by utilizing a form of expression that is not habitually defended against. This may allow the anorexic to reveal repressed emotions, thoughts or fantasies that have not emerged in verbal therapy treatment (Rehavia-Hanauer, 2003). By acknowledging her emotions,

the eating disordered individual may begin to gain awareness and responsibility for herself (Mitchell, 1980).

Schaverien (1995) proposed that creating art may be therapeutic to the eating disordered individual because art materials may symbolically represent food as the patient works through the underlying dynamics of the illness:

> In the case of severe eating disorders the client's relationship to food may be understood to be a means of negotiating and mediating between the internal world and the external world. It is proposed that pictures may also mediate between the inner and outer worlds of the client and so between the client and the therapist. As an object of transference itself, the art object may temporarily and unconsciously become a substitute for the use of food. (p. 31)

Both Schaverien (1995) and Levens (1990) suggest that eating disorder patients have difficulty symbolizing, as evidenced by the acting out of conflicts and denied emotions via their bodies. Schaverien suggests that the ability to use art materials instead of food to express experience marks the beginning of the ability to symbolize. To affirm this point, Schaverien coined the term *transactional object* to describe the relationship between the patient, the artwork and the therapist. According to Shaverien, a transactional object (the artwork) not only enables the patient to sustain a relationship with another person (the therapist) while they not physically present in the same area, but also allows the unconscious to be expressed on paper, which may lead to changes in behaviors, emotions and cognitions.

Levens (1990) and Rust (1995) observe that eating disordered patients seem to have difficulty recognizing and then managing their emotions without denying them. According to Levens, because art therapy provides a concrete object that can be regarded, touched and manipulated at any point in therapy, artwork may aid the

patient to stay with and work through previously denied emotions. In addition to drawing, one may cut, smear, splash or tear a piece of paper and then use the fragments to create something new. Furthermore, Levens argues that art making and the art object may be regarded as a mirror of the individual's internal world because it is dynamic in nature. For example, because artwork can be changeable and because one may produce multiple creations, art may reflect the shifting state of one's conscious and unconscious mind.

According to Schaverien (1995), artwork may create a safe space where new interactions between the self and environment may be tested. Furthermore, according to Shaverien, creating artwork plays a dual function. While it places one's fears and fantasies onto a piece of paper, thereby distancing oneself from that may be perceived as unacceptable, artwork also serves a confrontive function. One's fears and fantasies are brought to consciousness and are perceived visually, which may be a key factor in the recovery process. Elise Warriner (1995), an anorexic patient who wrote of her own experiences overcoming her illness, described the role of art therapy in her process of self-discovery:

> Strange as it may seem, anorexia and illustration have at least one thing in common. They are both about expressing oneself without using words, yet one is destructive and the other creative...One of the greatest assets of art therapy for me was that I had a creative space in which to explore my emotions...Putting emotions down on paper also helped to make them real. No longer could I reject them as a figment of imagination, invisible and therefore unimportant...To a certain extent, if anorexia was used as a numbing agent, art therapy brought the pain into the open. (pp. 24–25)

Rust (1995) points out that creating artwork promotes cognitive flexibility because artwork can hold many concepts within its bounds at one time. However, as alluded

to by Warriner (1995), Rust points out that participating in creative work can be similar to opening Pandora's Box: "Essential for this client group [eating disorders] is the discovery that they own their own desire and that it can lead to both creative and destructive ends" (p. 58). The author maintains that the discovery of this duality may be more manageable and connected to the body during creative expression rather than during a purely verbal interaction.

Art Therapy and the Treatment of Eating Disorders

Before discussing the use of art therapy in the treatment of eating disorders, it should be noted that a specification of which eating disorders were being examined has usually not been included in the reviewed art therapy literature. Within this context, the term *eating disorder* seems to commonly be used in reference to both anorexic and bulimic symptoms without distinguishing one from the other. However, literature that does discuss the differences in clinical presentation between the eating disorder subtypes seems to indicate that there is a difference in the artwork as well. Further research is needed to clarify this observation.

As stated above, eating disordered individuals tend to be resistant to treatment. Thus, a primary treatment goal often is the forming of a therapeutic alliance. As a result of the non-threatening nature of the art making process, anorexic patients may be able to foster a connection with the art therapist more readily than with verbal therapists. Allowing the first few sessions to remain primarily nonverbal in order to reduce anxiety surrounding the verbalization of symptoms and other issues that are being denied by the patient may be one method used to aid the development of the therapeutic alliance (Lubbers, 1991). Mitchell (1980) suggests that initially, art therapy treatment should be non-directive, meaning that the art therapist should allow the patient to spontaneously and freely express herself. Once the therapeutic

alliance has been established, Mitchell advises offering art directives that are related to the patient's treatment goals. In contrast, Levens (1987) often refrains from her usual non-directive approach when working with an eating disordered individual during the initial stages of therapy because, as she observed acting autonomously and with self-direction is often difficult for this population (Makin, 2000). Schaverien (1995) points out that interpreting patient artwork is often experienced as invasive by the eating disordered individual and should therefore be avoided by the art therapist.

Due to the developmental nature of the conflicts underlying both anorexia and bulimia, art therapy treatment goals should often address nurturance, control, personal effectiveness, self-esteem, emotional experiences, interpersonal relationships and perceptions of the self. Anorexics commonly seem to view the world as a series of dichotomies, where they often use the defense of splitting and demonstrate the inability to integrate different aspects of the self in unison. Therefore, broadening their perspective of the world and of themselves is a treatment goal that can be realized through the encouragement of a wide range of color use, media choices and space. Directives that invite the patient to admit feelings of deficiency in regards to autonomy and personal efficacy should be utilized in order to help the patient achieve the goal of expressing emotions. In order to build on what these individuals are psychologically struggling with, directives that augment one's sense of autonomy, self esteem and self-effectiveness should be utilized (Lubbers, 1991). A goal of functioning positively in group situations may be useful for this population since interpersonal relationships may be confusing and even anxiety provoking to the anorexic patient (Mitchell, 1980). Lastly, recognition of distortions is important, but may be hindered by the patient's resistance, repression and denial. Lubbers (1991) discusses the delusional magnitude of the distortion of body image commonly found with eating disordered populations. She suggests exploring cause and effect relationships, as well as directives may be

used to investigate one's body image. Mitchell (1980) suggests the use of techniques such as body tracing. Using a life-sized piece of mural paper, the patient is asked to draw an outline of her body as she perceives it. Once this is completed the patient stands against the mural paper, and her actual body is traced using a different color. This directive is intended to confront the body distortions of these individuals and promote reality testing.

Luzzatto (1995), who subscribes to the object relations school of psychology, proposes that after building a strong therapeutic alliance the therapist should aid the patient to visualize her mental self-image through the creation of artwork. Once the patient is capable of this, therapy continues by exploring the dynamics of the self-image and the potential to change the internalized object relationships that comprise the internal world of the patient.

Rust (1995) described her experiences in conducting group art therapy with eating disordered patients for one year. The author described what she interpreted as a sense of fear within the group, expressed by an unspoken rule of not crossing over into another's boundaries and wanting to remain separate from the group members. For example, themes of intrusion, such as tapeworms or alien creatures living inside their bodies were common topics in the verbalizations of the group. Rust parallels these observations with the perceived experiences of the patients within their own families, where perhaps their boundaries were intruded upon or where parents were seen as parasitic.

Art Materials

Fleming (1989) and Makin (2000) discuss the importance of media choice with anorexic patients according to the stage of treatment. A quote from an anorexic male, whose case is discussed in the subsection Art Therapy and Men with Eating

Disorders, illustrates this point,

> Perhaps the best way I can explain the process and benefit of art therapy is to discuss briefly a series of my own drawings. The fact that they are drawings, and not paintings, relates directly to my illness — a yearning for neatness, order and often meticulous detail. Painting would have been too messy and the 'safe' control of drawing had with it a sense of security. (Shaverien, 1995, p. 62)

According to Fleming (1989), the use of collage or placing borders around paper may be helpful in the initial stages of therapy to help reduce anxiety during the art making process. Similarly, Makin (2000) discusses the use of collage as a non-threatening introduction into the art therapy, where pre-cut images reduce the anxiety associated with creating a perfect product, a common obsession amongst anorexic patients. Flipping through magazines may be soothing to bulimic patients who make their way through stacks of magazines without restraint. "Cutting and pasting and arranging words and images on the page offers a whole other set of opportunities for play, reflection and a sense of accomplishment" (p. 91). During the initial stages of therapy Fleming (1989) also recommends using other types of structured art media that the patient may already be accustomed to using, i.e., pencils, markers or crayons. These materials may be viewed as calming and comforting due to their familiarity and controllability. Furthermore, these materials may promote intellectual responses, which is often a strength found in this population.

Makin (2000) describes pastels as "the middle ground between drawing materials and paint" (p. 95). Oil pastels are similar to crayons and are applied and smudged with a heavier hand, making thick lines of color. In contrast, chalk pastels are applied with a lighter touch and are easily smudged, and have a more transparent quality. During the mid-stage of therapy, Fleming (1989) suggests the use of more fluid or

unstructured media, such as pastels or paint, in order to encourage the expression of affect. One must note that using less structured materials may encourage regression and anxiety due to the similar textures between these media and bodily fluids. If this occurs, Fleming suggests returning to more structured media that may have been experienced as soothing to the patient during the beginning stages of therapy.

Makin (2000) describes the tendency for anorexics to favor chalk pastels, as they have a gentler quality than oils. Anorexics also tend to be more comfortable with using watercolors, as they are often applied with fine brushes onto small pieces of paper. On the other hand, bulimics tend to apply thick layers of acrylic paint, saturating large pieces of paper with wider brushes. While bulimics tend to be more comfortable with using finger paints, anorexics tend to be challenged by this task due to the lack of control one has while using finger paints and the direct physical contact with the paint. As stated previously, the fluidity of unstructured media, such as paint may promote regression and cause anxiety due to the connection between the nature of the media and the body (Fleming, 1989). However, according to Makin (2000), using media such as finger paint may cause images to emerge spontaneously and unconsciously.

When exploring three-dimensional media, Makin (2000) notes that anorexics tend to favor plasticine due to its ability to be formed into miniature figures with fine details. Bulimics, however, have little difficulty engaging with any type of clay material, often molding large shapes or figures. "Opportunities to work with modeling materials, including clay, make possible the creation of many imaginative structures that can give different impressions and meanings because they are off the page" (p. 102). Makin does recognize that there are some individuals, regardless of their diagnosis, that are particularly uncomfortable with the use of clay, in which case other three-dimensional materials may be used to sculpt a piece. As an example, Makin includes pictures of sculptures using a plastic hat, pipe cleaners, pom-poms and tissue

paper.

Flemming (1989) also makes recommendations for structuring art therapy sessions during the termination phase. She suggests reviewing previously completed artwork and addressing issues of loss during the termination phase of therapy. Re-examining artwork may also support the patient's more constructive defenses and aid in concretizing the progress made during therapy. Furthermore, it is common for a patient to regress during the termination phase, which also is suggested to be a topic of therapeutic exploration.

Makin (2000) dedicates a chapter to patterns she has observed in her work with eating disordered patients. Although Makin integrates creative journaling and poetry with art therapy as a part of her therapeutic style, this paragraph will mainly focus on the artwork of anorexic and bulimic patients. In terms of drawing materials, Makin notes that anorexics tend to be more comfortable making faint marks with structured media such as pencils, while bulimics often make "bold strokes, even extending off and through the page" (p. 90). She observes that eating disordered patients may become enthusiastic about craft making and may place beads and/or sparkles on their work, which may cause the art therapist to question the direction of the therapy session. However, Makin points out that often there is no need to worry since the underlying dynamics are naturally incorporated even in non-directive craft groups. For example, Makin discusses a t-shirt making group where the patients still focused on their eating disorder issues, although they stated that their intention was to "have fun". One patient created a t-shirt with the writing "Member Of The 100 lbs Club", which was intended as a statement of the patient's current relationship with her eating disorder.

Makin (2000) notes that the use of color varies between the diagnoses of anorexia and bulimia. Anorexics tend to restrict their color use, and will often choose a lead

pencil as their first media choice. Bulimics, on the other hand, tend to use bold colors during their first art therapy session and prefer unstructured media such as oil pastels, paint or clay. Furthermore, Makin notes that bulimics tend to be comfortable using a variety of media in their artwork, while anorexics may only begin to experiment with several types of media on one page once their self-confidence has increased and the need for control has decreased.

Matto (1997) incorporates a cognitive-behavioral approach to using art materials with eating disordered patients. Due to the common presence of obsessions surrounding the idea of perfection, many eating disordered patients participate in the art making process with the intent of making the *perfect picture*. Offering collage materials during initial art therapy sessions may reduce the patient's anxiety surrounding this notion (Fleming, 1989). When sufficient ego strength is present, Matto proposes suggesting that the patient use a variety of art materials. By doing this, the therapist is symbolically challenging dysfunctional belief systems. Furthermore, creating artwork, especially when using unfamiliar materials, offers an endless amount of choice and possibilities, something that eating disordered patients are often reluctant to acknowledge in their own lives. Matto also suggests using collage media taken from contemporary magazines in order to explore cultural ideals in context. This may allow the patient to investigate her beliefs regarding oneself and the world, in order to challenge erroneous self-statements.

Hinz & Ragsdell (1990) described the use of mask making and videotape in a long-term outpatient art therapy group consisting of nine bulimic women. The group was directed to create masks for a one-hour session. The next session consisted of the patients reading several questions into the videocamera while holding the mask over their faces. Two subsequent sessions were dedicated to each individual reviewing their videotaped session, and answering the questions asked during the previous

group. Hinz and Ragsdell hypothesized that since masks are thought represent a persona that is not overtly expressed, the interaction between the masked and the unmasked self would facilitate self-awareness, integration of the unacceptable part of the self and self-acceptance. 89% of the group participated in the mask making, 56% completed the videotaped session and 33% responded to the taped questions. After the videotaped session, the participants reported feeling uncomfortable and often criticized their appearance on tape. The authors propose that this was an example of patient resistance and noted that the more committed group members, who may have been farther along in the treatment process, "realize[d] that they alone were responsible for recovery from the disorder" (p. 260). For the three group members who completed the full directive, discussions focused around the conflict between feeling the need to hide their real selves and presenting their false selves to the world because they perceived their false selves as being more pleasing to others.

The Artwork of Eating Disordered Patients

There are several characteristics noted to occur within the artwork of eating disordered patients that will be described in detail throughout this subsection. As stated in the previous subsection, as well as in the subsection entitled Developmental Issues, patients with eating disorders often present with a deficit in the ability to symbolize (Levens, 1987; Shaverien, 1995). Therefore the initial artwork of these patients may begin at a pre-symbolic level with a jumble of sensation, color, and form (Johnson & Parkinson, 1999). Artwork may be used as a form of communication to the therapist and/or the group, marking the first attempts to move towards symbolization rather than acting out on the body (Dokter, 1995; Johnson & Parkinson, 1999). As will be discussed in more detail below, anorexics mostly incorporate pleasant subject matter, light line quality, small images, small paper sizes, structured media, lack of color,

rigidity and androgynous looking individuals. In contrast, bulimics tend to make use of the entire page — sometimes extending off the page — and prefer unstructured media. For example,

> The anorexic is sometimes frightened of putting anything on paper in case it gets out of control. The bulimic, on the other hand, is often frightened by the strength of her own feelings, which are allowed a 'safe' outlet through art. Bulimics frequently leave little space unoccupied and are often 'envied' by the more restrained anorexics for their ability to express themselves more freely. (Makin, 2000, p. 121)

As explained below, the artwork of each eating disorder subtype reflects the underlying dynamics and symptoms of the individual. It should be noted that no articles were found describing the artwork of individuals with eating disorder NOS or binge eating disorder.

Mitchell (1980) describes the initial artwork produced by anorexics as "'pleasing' pictures...for example, flowers, cute animals, happy people" (p. 60), which may represent denial and the ego syntonic nature of the illness. Lubbers (1991) adds to these ideas by describing the work of patients she had worked alongside. She described the artwork as sometimes containing a light line quality, no facial features and no hands or feet on human figures. These characteristics may symbolize lack of autonomy and lack of sense of self. Human figures may be drawn with asexual features, corresponding to an underlying fear of maturation. The distorted manner in which these individuals regard their bodies may also be clearly evident in their artwork, for example by including imagery of the self with a large stomach area. In addition, an elongated neck may be included, suggesting the separation on mind and body, which may related to a strong sense of denial and the use of intellectualization. Themes of power struggles and control may be observed as well, for example through the discussion of hospital

staff, which may parallel the perceived parent-child relationship.

Crowl (1980) described three areas of conflict in anorexic artwork by examining the artistic productions of twelve anorexic adolescent girls who were between the ages of 11 and 16. The conflicts that emerged may be summarized as follows: a) self image; b) self-esteem; and c) control. For example, Crowl notes that when these patients were directed to draw themselves, the images that emerged were that of young children, suggesting the self-image of a little girl. The majority of the images were marked by "smiling faces, immature bodies, girlish decorations of hair ribbons, ruffles and bows" (p. 143). The author connects these images with the clinical observation that anorexics restrict their diet to be in command of their sexual maturity. Crowl notes that these patients have low self-esteem, as indicated by small figures and small drawing surfaces that are often used by anorexics. Lastly, the artwork of the anorexic sample was found to be rigid and methodical, symbolizing the obsessional control these individuals exert in all aspects of their lives, including in the arena of food. Stereotyped symbols and repetitious patterns were found to be common, as was the embellishment or decoration of figures or objects in the artwork. In addition, the separation of mind and body was noted to occur in the artwork of Crowl's patients; the author observed human figures in the artwork whose heads were separated from their bodies with chains around the throat area.

Makin (2000) describes the Goldsmith's College Study conducted by Waller (1981), which studied art therapy in the treatment of eating disorders. The subjects were given directives that were intended to target body image distortion. Using media such as video, masks, makeup and paint, the subjects were asked to create images of both their ideal self and their *other self*. The results of the study were that anorexic patients rarely included the human figure in their artwork. When the human figure was present, it tended either to be represented as tall, thin, childlike and androgy-

nous, or as a feminine little girl, which may represent the difficulty this population has with maturity and sexuality. The images were found to express isolation from family and friends and often referenced being teased or bullied.

Four categories of imagery were found within the artwork of the subjects, which correspond to the stages of therapy:

1. Concise extrinsic patterns; for example, whirlpools and bottomless pits
2. Animals, usually dogs and horses
3. Flowers and plants, cacti and thorns
4. Landscapes and gardens. (p. 57)

The study offered possible interpretations of the four categories, where the whirlpools and pits may represent social isolation and difficulties with self-expression. The animals may reflect over-exercise behaviors that are common with this patient population. The plant life, noted as having been drawn with great detail and control, was suggested to symbolize the perception of the self. Lastly, the landscape category was proposed by Makin to relate to Jungian "archetypal configurations" (p. 57). In addition, the study noted that as therapy progressed, the imagery seemed to become more expressive. Subsequent to this expressive period, however, the patients tended to return to more concise drawing patterns, which was said to correspond to a return to more regressive behavior, such as restricting behaviors or obsessional hand washing (Makin, 2000).

Levens (1990) noted parallels between the artwork of eating disorder patients and individuals with borderline personality disorder. The author writes about her experiences conducting individual art therapy sessions and groups with a chronic female eating disordered population over a five year period. Levens describes drawings with

"blurred body boundaries, with parts of other people intruding into the picture of themselves, giving a hint of an experience of non-separation, of a lack of a distinct body self" (p. 278). Furthermore, similar to those with borderline personality disorder, eating disorder patients "often have a deep mistrust of words, which are also things which they know well how to manipulate and which may be distanced from any real meaning for them" (p. 279). Eating disorder patients also tend to describe themselves as lacking a voice, where they may feel they are not heard by family members. Therefore, Levens discusses the value of art making with this population, where patients may discover the meaning of their own marks by exploring the artwork without the therapist interpreting or elaborating on the images or verbalizations. The role of the therapist, therefore, especially in the initial stages of treatment is to reflect back the patient's verbalizations.

Rehavia-Hanauer (2003) conducted a qualitative study of 10 anorexic patients who participated in weekly art therapy sessions over a four year period. Using *cyclical grounded theory*, which is a type of qualitative methodology for developing theory that is developed through repeated cycles of systematically gathered and analyzed data, the author found six main conflicts to be present as seen through the artwork, behaviors, and verbalizations of the study group. Two art therapist readers corroborated the presence of these conflicts, where the inter-rater reliability was found to be between approximately 82–84%. It should be noted that "this set of indicators is not to be taken as a classification system that can be used in isolation for diagnosis. These indicators need to be considered together in their context" (p. 141).

The results of the study are as follows: Conflict one, which commonly emerges in the initial stages of therapy, is described as verbal, emotional and/or behavioral resistance to art therapy and the creative process, although the individual may communicate curiosity or desire to interact with the art materials. Some verbal indicators

of resistance are listed as statements of hostility, contempt, suspicion, passive resistance and devaluation. Behaviorally, the subjects may have objected to art therapy by, for example, hiding in a corner or placing her head upon the table. Yet, these same participants were also noted to touch the art materials, ask how to use the art materials, discuss previous artistic experiences, and/or begin creating artwork.

The second conflict was found to be the intensive creation of artwork followed by the desire to destroy the piece. This period was marked by the anorexic attempting to make her artwork accurate, controlled, and beautiful. This may be completed through careful use and application of color, or by adding decorations to the piece. Once the art making was completed, however, the patient was found to express disgust or make statements of devaluation, sometimes followed by the desire to destroy the piece perhaps with scissors or by throwing the piece in the garbage.

The third conflict is described as "the desire and need to be looked after and held and the verbal inability to directly express this desire and need" (p. 142). Rehavia-Hanauer (2003) states that the more engulfed an individual is in her symptoms, the more likely this conflict will become apparent. Depending on the status of the patient, this conflict may emerge at any time in treatment. Thematically, figures in need of assistance may be present in the artwork:

> For example, one patient drew a very thin female figure lying diagonally (in an impossible position) above a sharp sword pointed at her back. The figure faces death and will not be able to hold herself from falling on the sword. (p. 143)

Other examples include depicting a figure that is drowning, babies in cribs, or young birds in a nest. The need for a holding environment often is expressed through the theme of death or the womb. For example, imagery may include graves or a person

bleeding as they lie in a bed of clouds. Despite these visual metaphors, subjects tend to verbally deny their illness.

After resistance to treatment has been addressed, the fourth conflict was found to emerge. Involving the desire to be both dependent and independent in relationships with others, the patient behaviors and artwork reflect the desire to be symbiotic with others while remaining autonomous. Rehavia-Hanauer offers the example of an anorexic patient who drew a boat sitting in calm waters with a small island in the background. The patient begins describing a fantasy where the boat transports her to the island where she could live in a small house. She then began describing the boat taking her to the people she loves, so that they could all go on holiday together "in a terrible place...eh eh (self correction)...a calm place" (p. 144).

The fifth conflict was found involve the development and rejection of female sexuality and identity. Rehavia-Hanauer suggests that as the re-feeding process takes place, anorexics experience bodily changes associated with puberty — for example, the development of breasts, genital hair and the re-commencement of one's menstrual cycle. Due to these bodily changes and the emotions and cognitions associated with them, the patient may begin verbally, behaviorally and artistically expressing fear and disgust with one's body. For example, the individual may exclude body parts or sexual indicators in the artwork. The individual may also begin to perform self-aggressive behaviors such as extreme self-cleaning, the reinstatement of restrictive dietary practices, and denial of rest. Artistically, this may be depicted through images such as female figures that are tied, hung, burnt, or dead.

The sixth and final conflict found by Rehavia-Hanauer is described as "the need for complete control and the feeling of lack of control" (p. 146). This conflict is present throughout the treatment process of anorexia nervosa and in particular when physical changes are taking place or when new societal demands are made. Behaviorally, this is

most obviously observed by a demonstration of control regarding food intake. Verbal expressions of omnipotence were also found to be present, such as an anorexic patient explaining that she was a "bad child" when she was three years old, which caused her mother to become chronically ill. Artistically, an anorexic patient may refuse to create new artwork for fear the final project will not be perfect or meet a perceived standard. The patient may refuse to work with less structured media such as paint or clay, which is more difficult to control. Instead, the patient may prefer to work with pencil or markers. Refusal to produce artwork may also reflect the need for control, as several subjects described by Rehavia-Hanauer expressed a fear regarding what may be revealed in their artwork. They described feeling they had more of a command over the words they spoke than the artwork they made.

Luzzatto (1995) describes a directive that she developed from the common features found within the artwork of anorexic patients along with Winnicot's conceptualization of the self in relation to the world. Luzzatto explains,

> In psychoanalytic literature, the internal world is often presented in visual terms...Following Winnicot very closely, a basic visual representation of the self may be conceived, in a two-dimensional drawing, as an outline which separates Self from World/Others. (p. 61)

Figure 1 is a graphic representation of this self/world relationship.

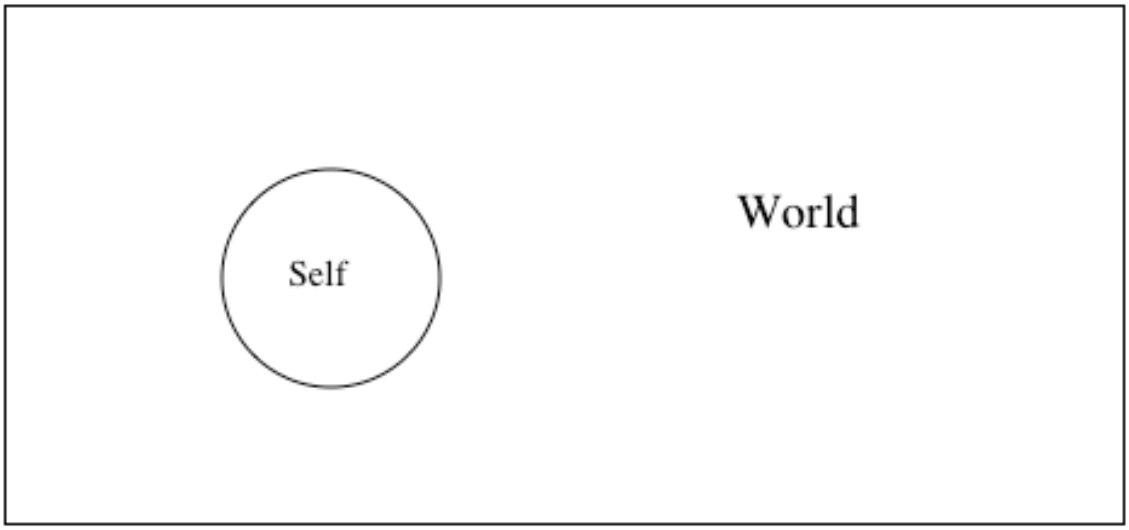

Figure 1: The mental self-image (Luzzatto, 1995, p. 61)

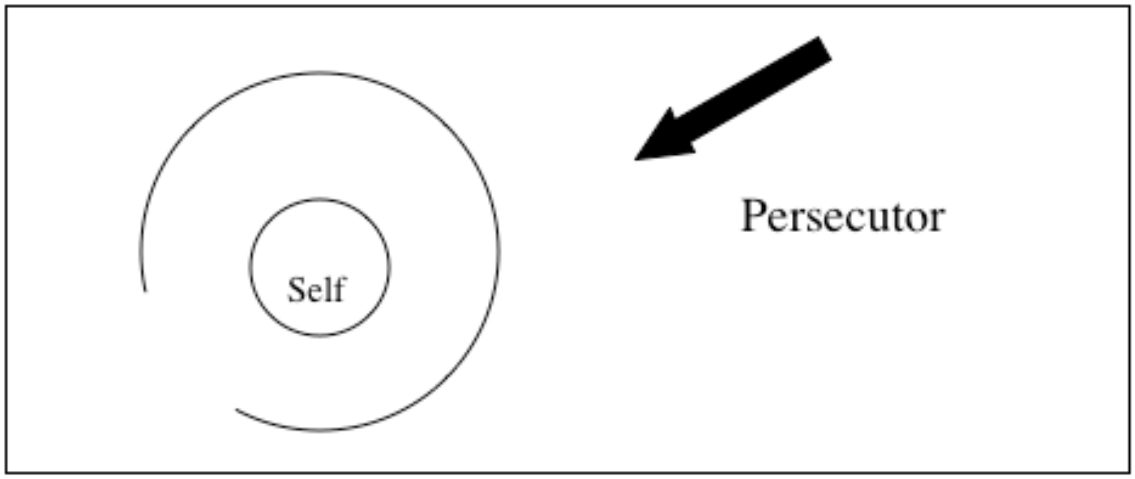

Figure 2: The double trap (Luzzatto, 1995, p. 63)

Incorporating Winnicot's conceptualization of self-image, Luzzatto describes an art therapy directive that she commonly conducts with anorexic patients. She offers

the patients a white piece of paper and asks them to imagine the paper as their world. She then encourages them to use abstract shapes and colors to express the boundaries of the self, the inner world of the self (i.e. emotions and thoughts), and the space outside the self (i.e. the world). The author has noticed that anorexics tend to express their self-image in similar ways, which the author has dubbed the *mental double trap* (see Figure 2). The mental double trap includes three basic elements,

> " (1) **The Self**. The self is visualized as something quite small, vulnerable, often precious (it may be a little dot, or a foetus-like shape, or a little animal like a skinny bird, or a small goldfish, or a mermaid). (2) **The Prison**. The self is contained inside a prison, or imprisoned by somebody, or a group of objects. The prison has at the same time a negative and positive meaning: negative because it is a prison, positive because it is also a protective barrier against an external persecutor. (3) **The Persecutor**. There is something threatening or persecutory in the external world (it is often visualized as an aggressive shape, or a threatening colour, or a devouring animal). The persecutor is ready to attack the self, in case the self should escape from the prison. The presence of the persecutor justifies the immobility and hopelessness of the self inside the prison" (pp. 62–63).

Luzzatto (1995) continues by explaining variations on the general theme of the double trap. Figure 3 is an example of how the prison and persecutor can merge into the same symbol, where either the persecutor is imprisoning the victim or the prison is considered persecutory. Figure 4 is an example of when there the presence of a "good object" in the drawing; however, the good object does not serve a protective function and is unattainable.

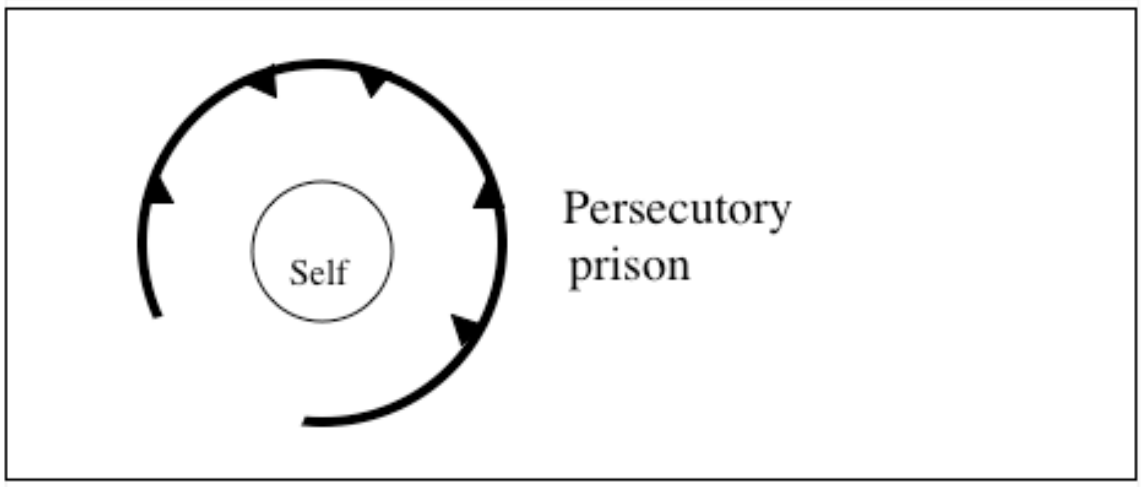

Figure 3: A variant of the double trap – I (Luzzatto, 1995, p. 63)

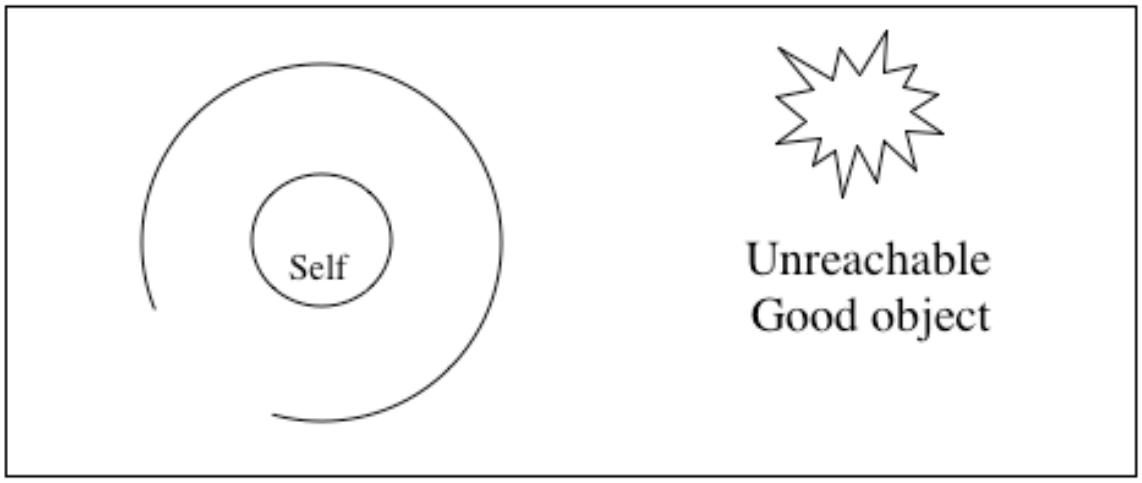

Figure 4: A variant of the double trap – II (Luzzatto, 1995, p. 64)

Luzzatto (1995) stresses that the art therapist must use both respect and caution, as well as a non-judgmental and non-confrontational therapeutic style, when exploring the meaning of self-image drawings with the patient. The goal of therapy in this case

is to help the patient reduce the power of the persecutor as an internal object, while simultaneously encouraging "the little self [to] gain strength" (p. 67). As such, this process is intended to unfold over several sessions; Luzzatto describes a case study of an anorexic male who explores his self-image over seventeen sessions (see the section entitled Art Therapy and Men with Eating Disorders).

Although the majority of art therapy literature focuses on anorexia, there are some writings that explore the dynamics of the bulimic patient and the use of art materials. Makin (2000) explains that because a bulimic is "all over the place, physically and emotionally...so is her art-making. Her responses to treatment are complicated by her fluctuations in mood, motivation and damaged and confused senses of appropriateness" (p. 60). Gillespie (1996) noted that bulimic patients tend to draw people hyper-realistically, emphasizing feminine sexual characteristics and elaborate clothing. It should be noted, however, that adolescents tend to emphasize realism, fashion trends and the sexual characteristics of figures in their artwork (Lowenfeld & Brittain, 1982). Levens (1987) describes a bulimic patient that used a large amount of paint and paper to create what the author describes as a vomit picture. Levens (1987) cautions that art making is not about an alternative way of purging one's feelings, since this would not create internal change in the patient. For change to occur, Levens argues that both the patient and therapist must be actively reflecting upon and understanding what is unfolding within the therapy session. One must be cautious not to reinforce acting out behaviors during the therapy session, and rather emphasize self-awareness, for example of one's emotions.

Certain metaphors have been noted by Makin (2000) as common within the drawings of eating disordered patients. Images of spirituality and death such as tombstones, crosses and graves, tend to be included in artwork when an impasse occurs in treatment. Tornados were also mentioned as a reoccurring theme. In addition, Makin

states that mountains were commonly represented in patient artwork. Mountains are often thought to symbolically represent both mother and or a journey. Eating disordered patients may draw an individual climbing a steep mountain, where the mountain was explained to represent recovery. Images of being trapped, for example in a cage, and ridiculed by others may be commonly found in the artwork of eating disorder patients. This description seems to correspond to Luzzatto's (1995) description of the mental double trap (see Figure 2). Lastly, Makin (2000) also found drawings depicting ideal home situations or intricate doodles to commonly occur within the artwork of eating disorder patients.

As stated in the subsection Risk Factors of Eating Disorders, childhood abuse has been implicated as a risk factor leading to the development of an eating disorder (Mangweth et al., 2005). Therefore artistic indicators of abuse may be present in the artwork of eating disordered patients. Makin (2000) discussed the work of Sandra Ticen (1990), an art therapist who worked with eating disordered patients. Ticen noted indications of sexual abuse in female patients with eating disorders. For example,

> A preoccupation with food [may be] less disturbing than the intrusive thoughts of trauma, victims give themselves a sense of control through it...the more traumatized the victim, the more restricted the art will be, and...'With consistent, ongoing abreactive work in art therapy, the imagery will gradually become more fluid, more colorful, more integrated and more dynamic'. (Makin, 2000, p. 65)

Art Therapy and Men with Eating Disorders

Four case studies written by art therapists working with male eating disorder patients have been found and will be discussed in detail in this subsection. Similar

to the artwork of women with anorexia, these cases involve resistance to treatment, isolation, themes of death and entrapment, disintegration and family conflicts (see the previous section entitled The Artwork of Eating Disordered Patients).

The first case study published describing the use of art therapy with an eating disordered male was written by Connie Naitove (1986). Naitove recounts the case of a 16-year-old male named Doug who suffered from both anorexic and bulimic symptoms. Naitove begins her portrayal of Doug by explaining the family situation and life stressors that precipitated Doug's eating disorder. Doug was of European decent and was the youngest of three children. He grew up in a tropical country outside the United States, but was sent by his parents to the U.S. for three months in order to receive treatment for his eating disorder. According to the patient, the home environment was difficult due to marital discord between his father and mother, in which he was frequently directly involved, as well as his mother's successful battles with cancer that occurred both when Doug was aged 9 and 14. Ten months prior to his arrival in the United States, Doug's parents separated and his father moved out from the family home. Upon admission to therapy Doug was 6'0" and 110 lbs. His physician had noted both depressive symptoms and suicidal ideation along with restricting and purging behaviors. According to Naitove, the patient indicated an openness to therapy and explained his treatment goals as,

> Needing to gain weight (he had a habit of frequently measuring the size of his wrist by wrapping it with the first two fingers of the other hand and holding it out...), to be able to interrupt his obsessional preoccupation with his parents' marital problems, as well as to free himself of his mother's dependency and fears related to cancer.

Naitove described her treatment goals as aiding Doug to enhance his self-image, self-efficacy, and to support him in coping with the family dynamics upon returning

home. Naitove used an eclectic approach combining art, drama, movement and poetry, as well as transactional analysis and creative analysis in the therapeutic setting. The author provided Doug with a journal, which he could use to create artwork or record verbalizations spontaneously, in order to express both thoughts and emotions as he participated in the therapeutic process. In addition, Naitove notes that Doug's imagery often centered around his mother, suggesting identification and/or enmeshment. For example, when asked to draw a self-portrait, Doug drew a picture of his mother when she was first diagnosed with cancer. Naitove implies that themes regarding the patient's concern with his mother's past illnesses were alluded to throughout the case study, however, Naitove did not go into detail about these dynamics. One must be reminded of the fact that Doug's mother was possibly sick throughout his treatment as she did pass away approximately one year after treatment, as described below.

In the mid-section of the case study, Naitove (1986) discusses what may be described as resistant and manipulative behavior as Doug's treatment began unfolding. Doug began making a series of physical complaints that were later found to be psychosomatic. The patient was also found to be exaggerating about his academic achievements, for example by stating that he had graduated high school when he had only completed a high school equivalency exam. Doug would habitually drink from his therapist's mug, which was inscribed with the word "Boss". In addition, Doug began refraining from taking his medication as his mood and appetite improved during the second month of treatment. With regards to the creative arts therapy sessions, Doug would often choose to stand during sessions while the therapist presumably sat, stating that it allowed him to feel more in control. The patient also began refusing to include positive self-images or self-statements in his artwork and journal entries. It would seem as if an air of frustration is expressed within Naitove's writings as she

discusses several attempts to work through Doug's resistance to treatment. For example, Naitove incorporated the concepts of transactional analysis within suggested directives where the parent, adult and child were explored through dramatic improvisations and the creation of life-sized figures. Naitove directed Doug to use color to indicate where each psychological state resides. Naitove notes that feelings of guilt, ambiguity, and the need for control were present in Doug's artwork and verbalizations. Furthermore, themes of disintegration were present when it came time to confront the patient regarding the possibility of recovery. For example, Doug created a "droplet", which he said represents frustration and emptiness. The art therapist responded by stating,

> He could change the shape of his symbol for frustration and emptiness if he wanted to. 'But if I open it up, it'd splatter,' the contents would be dispersed and nothing would be left. He said that he would rather continue with his pain and anguish than surrender them and have no feelings left at all. (p. 113)

Upon discharge from his three-month therapeutic contract, Doug considered himself "basically all better" (p. 115). Naitove notes that the patient seemed melancholic. Doug's artwork affirmed this observation, by depicting a life-sized figure that was faceless, monochromatic and standing in an unbalanced position. Furthermore, his final art piece, a collage that depicted past, present and future, included an image under the word future of a surfer "dangerously close to [a] gigantic shark and nurse fish (either of which could devour the surfer)" (p. 115). Upon discharge Doug had gained 10 lbs and was considered to have a brighter affect than upon admission. When he returned back to his home country he enrolled in school and began outpatient therapy with a psychiatrist. Against the recommendations of Naitove, the psychiatrist retracted the eating disorder diagnosis and considered Doug "a severely depressed

young man grappling with issues that lay far outside his capacity in terms of his emotional repertoire" (p. 116). Naitove assures the reader that the treatment team working with Doug in the United States did not agree with this reevaluation, and Naitove provides a list of 32 eating disorder symptoms affecting him including the loss of at least 20% of one's body weight, purging behaviors, obsessive-compulsive thought patterns, impaired cognition and preoccupation with body size. It was reported that Doug ceased attending outpatient therapy after one month; however, he continued to gain weight and do well in school. Follow-up communications concluded after one year. Despite several significant life stressors that occurred during this time period, such as the death of Doug's mother, Naitove seems to remain optimistic that Doug had not succumbed to the physical effects of his eating disorder or followed through with any suicidal thoughts.

Luzzatto (1995) describes the case of a 21-year-old anorexic male named Francis in relation to her theory, the mental double trap (see the subsection entitled the Artwork of Eating Disordered Patients). The author clearly states that her intention in writing about this case "is not...to discuss anorexia in males, but an opportunity to present specific art therapy interventions" (p. 68). Luzzatto worked individually with Francis on an outpatient basis in conjunction with his primary care physician, after Francis refused to enter inpatient treatment. He was the second of three children and was living at home at the time of treatment with his parents and younger sister. Prior to receiving a diagnosis of anorexia nervosa, Francis had dropped out of school stating that he wanted to be home to "help his mother" and "write a novel". The information that follows is the result of seventeen individual art therapy sessions. The first five sessions were dedicated to assessment and allowing the patient's self-image to emerge. The subsequent twelve sessions focused upon issues agreed upon in the therapeutic contract. Luzzatto begins the case study by describing Francis' self-

image in his artwork, which emerged during the third art therapy session. The self was drawn inside a closed fist, considered to represent both prison and persecutor. Francis verbalized metaphors such as darkness, imprisonment, and suffocation to describe the self inside the hand. He described himself as both the self inside the fist and the fist itself,

> I get angry...I turn my anger against myself...I provoke pain to myself...I become the fist...I want to remain very tight, so much that I feel pain...I need to feel pain, so I do not think of what is behind the pain. I keep tight and I say NO...NO to letting go...I think that if I let go...I would disintegrate. (pp. 69–70)

Luzzatto suggests the prison (i.e. the fist) is both a vehicle for self-destruction and self-protection against disintegration, which demonstrates the mental double trap. In the same session Francis went on to connect the feeling of imprisonment with his family situation, where his father was abusive both to his older brother and his mother. He described wanting dual relationships with his parents, where he desired his father's attention while also wanting to kill him. Furthermore, Francis described wishing to protect his mother, but leave home at the same time. The patient also described ambivalent feelings towards therapy – he was not sure if it would be ultimately constructive or damaging. With prompting from the patient, the fist drawing was returned to and explored further during the fifth session. Here, Luzzatto asked Francis if there was an alternative to the self being encapsulated inside the fist and remaining unmoved. The patient responded by suggesting, "maybe I could try to open the hand" (p. 70). Francis created a new drawing with an open hand holding a small figure in the fetal position. This was followed by verbal metaphors such as cold, exposed, and fears of changing the physical position of the figure. Francis then began describing his interactions with his family and other people, where he expects to be

attacked or rejected due to his tendency to make provoking comments. Luzzatto notes that after this session resistance began to mount as the patient began arriving late to therapy, perhaps trying to provoke an anger reaction from the therapist. Luzzatto notes that in session five it became clear that the image of the fist may represent Francis himself, or an individual he has provoked into becoming the fist. The sixth session focused on the theme of persecution, where a dream was discussed about a Christ-like figure being beaten and tortured. The seventh session explored trust and vulnerability. Again, the hand symbol re-emerged in the artwork, although this time it was buried in mud and reaching outward, asking for help. Francis imagined someone pulling him up out of the mud and "then that person laughs at me, and drops me" (p. 72). Luzzatto connects the piece and verbalizations to Francis' possible belief that he cannot trust anyone, not his family or therapist, and that therapy will surely fail. Resistance becomes more evident when Francis admits to wanting to return to his previous coping style of restricting his dietary intake. The eighth session begins with a blind drawing, where Francis closed his eyes and allowed a pencil to move about the page in a free and relaxed manner. Luzzatto offered this directive in order to meet "the feeling in this session...that Francis does not want to communicate" (p. 72). Once the blind drawing is completed, Francis explains that he had created a wall around the paper and was imprisoned inside it. During the ninth through fourteenth sessions Francis seemed to become more receptive to his emotions, as he began exploring his wants and needs, as well as painful feelings such as jealousy and envy. He described feeling non-existent as the middle child in the family and expressed his ambivalence towards intimacy, admitting a fear of being either connected to or isolated from others. Furthermore, Luzzatto points out an oedipal preoccupation with his parents, where he wished for their relationship to end. The idea of using food to express his difficulties with interpersonal relationships began to be verbalized by

Francis in therapy. Sessions fourteen to sixteen marked the beginning of separation and individuation, as Francis decided to leave his parents' relationship to them, move out and begin a new job. Luzzatto describes an image made by Francis in these last sessions "in which, after having destroyed the phantasy of the little self inside the persecutory hand, he walks out as an adult" (p. 73).

Shaverien (1995) discusses the case of an anorexic male named Carlos in her book *Desire and the Female Therapist: Engendered gazes in Psychotherapy and Art Therapy*. Shaverien writes about Carlos primarily in order to discuss her experiences of erotic transference between a female therapist and a male patient. Although Carlos' case is described in great detail, for the purposes of this literature review only certain elements of the case and artwork will be addressed. The focus of this summary is to explore the symbolism found within the artwork as it relates to the diagnosis of anorexia nervosa. Furthermore, while some interpretations from Shaverien will be included, it should be noted that she takes both psychodynamic and Jungian perspectives.

Shaverien offers her view on the similarity and differences between the underlying dynamics of females and males with eating disorders:

> One of the commonly accepted explanations for the onset of anorexia is that it is a fear of becoming an adult. For the girl this means becoming a woman like her mother, menstruating and becoming capable of bearing children. It means leaving her mother to become like her [separation and individuation phase], to compete with her, possibly to oppose her during the oedipal phase...she may fear separation and leaving the state of dependency and to avoid this confrontation the anorexic becomes instead regressed and...totally dependent on her mother and also paradoxically, she controls her. The result here is that mother and daughter are bound

> together in fear of separation...A similar process may be operating for the male anorexic. However, the difference would be in the effects of his regression...To grow up and leave mother a male must leave his dependent state. He must relinquish his incestuous desire for the mother [resolution of the oedipal]. (p. 49)

Therefore, Shaverien posits that male anorexics have unsuccessfully dealt with the separation and individuation phase, which ultimately effects the resolution of the phallic phase. She discusses the writings of Jung (CW #5) who explains,

> Since incest must be avoided at all costs, the result is either the death of the son-lover or his self castration as a punishment...or else the sacrifice of instinctuality, and especially of sexuality, as a means of preventing or expiating the incestuous longing. (p. 72)

Shaverien argues that although female and male anorexics may present similarly in terms of their symptoms, the etiology of the underlying conflicts causing the eating disorder is slightly different in that with men, the unsuccessful resolution of the oedipal leads to the denial of one's instincts through self-starvation.

When Carlos entered inpatient treatment he was 23 years old, 5'9" and less than 84 pounds. He had been gradually restricting his dietary intake for four years and was socially isolated. He was living in his mother's home and reported spending his day following his mother from room to room, not permitting her to leave him alone. When admitted to the hospital, Carlos signed a therapeutic contract in which he agreed to remain in a private room with a bed and washroom until he met his goal weight. This took approximately 10 months to achieve. In this case study Shaverien (1995) reports that the strict adherence to this therapeutic contract allowed the patient to recreate the transference towards his mother and then begin the tumultuous separation and individuation phase with successful results.

In terms of family dynamics, Carlos was the oldest of six children, all of whom were female except the youngest child, who was born when Carlos was 12. The patient was born in South America and moved to England at the age of two, when his mother married a man who was not his natural father. Carlos was not made aware that he was raised by anyone other than his biological father, until during the current treatment period, when the secret was revealed in a family therapy session. However, even after this information was divulged to Carlos, his mother asked that it remain undisclosed to his sisters, as she feared they would look down upon her.

Throughout the course of art therapy treatment, Carlos would spontaneously include his mother in his artwork. During the initial stages of therapy, the patient depicted himself in a dependent and regressed state in relation to his mother. Shaverien (1995) offers an example where Carlos illustrated a womb-like circle that was incorporated into the mid-section of a tree. Carlos stated the tree was a "mum tree" (p. 68), which trapped the sphere inside its space. This may be interpreted as symbolically similar to a variation of the mental double trap proposed by Luzzatto (1995), where the prison and persecutor merge into one symbol (see the section entitled The Artwork of Eating Disordered Patients). In this case the "mum tree" may be symbolically acting as both prison and persecutor, because it enveloped a circle in the center of its structure. Spheres were a repetitive symbol in the artwork and usually contained images such as fetuses within their boundaries, which the patient usually identified as the self.

Although Shaverien mainly took a non-directive approach with Carlos, she did ask him to complete a family drawing during the mid-phase of treatment. Both mother and father stand in the background and are drawn with wings, similar to those of an angel. The five children stand in various positions in front of the parental figures. The males are cloaked in black, while the females wear white – all except for

Carlos, who is wearing a black and white cloak, which is meant to convey the idea of sexual confusion although Carlos identifies primarily as a homosexual. All figures have faces except for the mother figure, who has sunrays emanating from her blank face suggesting the idealization of mother image.

Shaverien discusses the family drawing in relation to the other drawings created by the patient. Out of the 40 or so pieces of artwork produced by Carlos during his treatment period only three remained hidden from public view. The family drawing was kept under the bed, along with a drawing that directly portrayed Carlos' relationship with his mother. The third drawing, the patient's earliest memory, was destroyed by the patient in an attempt to repress this long buried memory. According to Shaverien, these three drawings each had elements that "had been repressed, or previously unconscious, [or] was admitted to consciousness" (p. 56).

As stated above (see section entitled Art Therapy and Eating Disorders) Shaverien (1995) advocates a non-directive approach, where the art therapist rarely offers interpretations during the processing of patient artwork. Therefore the majority of the images discussed in the case of Carlos were spontaneously made with art materials that the art therapist had left in the patient's room. In fact, most of Carlos' artwork seems to have been produced without the presence of the art therapist. The patient also admitted to creating numerous sketches before initiating his final artistic products, which may be an indication of his need for control in all aspects of his life.

There are several themes that seem to emerge in Carlos' artwork. Shaverien (1995) noted throughout the case study visual imagery depicting "the struggle to separate from the internalized mother, or mother image" (p. 60). Along these lines, the womb, fetuses, eggs and bubbles were reoccurring metaphors in Carlos' artwork. Shaverien also notes themes of control, dependency, passive aggression and regression in the patient's artwork. Shaverien also observes religious themes such as crucifixes and

archetypal images such as the sun emerged throughout the treatment period. During the initial stages of art therapy, Carlos often depicted the self as an animal, where as after a few months of treatment he began regularly drawing himself as a human. For example, Carlos produced a picture with an animal figure fearfully opening a door, suggesting the initial stages of exposing unconscious material. Towards the end of treatment, the human figures became increasingly less childlike, and included more detail in the face and body. This process may be linked with the conflict of denying one's sexuality, where as the patient begins integrating split or denied aspects of the self, self-imagery tends to become more realistic. In addition, trees were often prominent in Carlos' artwork, which the patient often stated represent either himself or his mother. In the initial stages of treatment Carlos became suicidal and expressed a sense of hopelessness through images of bottomless pits and figures who were bleeding and seemed to be lying lifeless on the ground.

According to Shaverien (1995), as separation and individuation began taking place, Carlos began eating normally and stopped trying to manipulate his weight by hiding food or vomiting after meals. This period corresponded to a series of violent and aggressive images of, for example, cloaked figures stabbing one another, which may indicate that long repressed anger was beginning to become conscious for Carlos. Themes of imprisonment also came to the forefront, perhaps paralleling the patient's situation of being in a locked room during the majority of his inpatient treatment. One must note that the theme of imprisonment is common within the artwork of anorexics, as has been described in Luzzatto's (1995) theory of the mental double trap (see section entitled The Artwork of Eating Disordered Patients). According to the verbalizations of the patient, Shaverien (1995) describes this period as both frightening and freeing. Similar to a study conducted by Waller (1981), periods of regression occurred as the process of separation continued and Carlos began inte-

grating aspects of himself that had previously been denied. Shaverien (1995) notes that although the imagery during this time period was similar to earlier imagery, the metaphors were slightly altered. For example, the previously mentioned bleeding figure lying on the ground returns in later drawings as a standing figure on a winding path. Shaverien notes, "this is a part of the process, a movement forward and a return to the earlier state, but from a different position" (p. 97). Throughout this process themes of rebirth and a spiritual quest or journey were also visually expressed in the artwork. For example, Carlos drew a picture of a tree with leaves on one side and bear on the other, "The tree...which Carlos describes as half-grown symbolizes himself, half-alive and half-dormant" (p. 94). The tree is growing on a path extending off the horizon into a pyramid shape, which Shaverien explains may have either masculine or spiritual associations. Carlos wrote a brief explanation on the back of this drawing: "The tree (me) is half grown...and longs to go away, very, very far away (pyramids)" (p. 94).

As the separation and individuation phase continued, Shaverien (1995) noted that a pattern began emerging "whereby one negative or painfully difficult image [was] followed, a few days later, with a positive one. This seems to echo his mood swings at this time and reflects the process of integrating his conflicting feelings" (p. 99). Furthermore, less social isolation was observed in Carlos' visual imagery. For example, the patient began spontaneously drawing bridges and two trees reaching for each other. Shaverien notes that the hero archetype emerged in the patient's drawings towards the last phase of the treatment period, where Carlos drew a male figure holding a sword to the air and facing a large sun. Shaverien points out that the figure seems to have emerged victorious over adversity, gripping his sword as if he was claiming his masculinity, sexuality, anger and power. After 10 months Carlos reached his goal weight, and was able to enter the art therapy room to create artwork. Carlos stopped

making rough sketches before creating artwork and began using larger pieces of paper and paint, which suggests improvement in his ability to be flexible, spontaneous, and less controlled in his thoughts and behaviors. His imagery seemed to suggest more confidence with his sexuality and with his conceptualization of masculinity, anger and power, as well as hopefulness for the future. According to Shaverien's interpretation, Carlos' last drawing seems to incorporate the Jungian concept of the shadow, which was not included in earlier works, suggesting that he is integrating previously unacceptable aspects of the self. At the beginning of treatment Carlos depicted ideal images, whereas during the last stage of inpatient treatment he began acknowledging and incorporating the split off, unacceptable aspects of the self into his artwork. The case study concludes with a small amount of follow up information regarding Carlos eleven months after leaving inpatient treatment. He returned back to his family's home upon discharge, was able to maintain is body weight and returned to school.

Cleveland (1999) included a case on an eating disordered male within Malchiodi's book (1999) *Medical Art Therapy with Children.* Cleveland describes the case of a 16-year-old male named John, who was admitted to a locked psychiatric unit within a children's medical hospital for short-term treatment and stabilization, although in total, his treatment lasted two and a half months. John acknowledged having an 18-month history of anorexia nervosa and had been restricting his dietary intake for approximately two months prior to admission in order to enhance his performance in his chosen sport. The patient was also suffering from a range of medical complications including a weakened immune system and impaired cognition. His family noted that John seemed irritable and socially isolated prior to his admission. Cleveland chose to begin art therapy treatment with the Diagnostic Drawing Series (DDS), which is an art-based assessment. The DDS provides information about the patient's emotional and cognitive functioning, based on information gathered from each individual task

in a series of three pastel drawings and the patient's response to the sequence of tasks. The first directive, *make a picture using these materials*, may be regarded as "a graphic representation of the client's defense system" (p. 58).

John responded to this directive by drawing a landscape, including a tree and hills. He stated that his drawing was similar to one he had created in elementary school, and that he associated the tree with loneliness. The second directive of the DDS is draw a tree, which may result in a less guarded response than the first drawing and is often regarded as a symbolic self-portrait. Here, John created a tall tree that was described as weathered, natural, and exposed to the elements. Cleveland notes differences between the trees in both drawings. The first tree appeared grounded and round, with its branches and leaves intact, whereas the second tree was ungrounded and had a long thin trunk with fragmented branches. Cleveland notes that these two drawings offer valuable information regarding the patient's defensive style; initially, John may present as stable, under the surface he may be fragmented and ungrounded. In the third directive, the patient was asked to *make a picture of how you're feeling using lines, shapes and colors.* John drew "an abstract image of concentric circles expanding outward. This seemed to reflect a willingness and ability to think abstractly and begin to address concerns more directly in art therapy" (p. 59). Cleveland then describes a session that occurred in the mid-phase of treatment, after the therapeutic alliance had been established, where the art therapist asked the patient to visually depict his illness. Next, John was asked to draw himself in relation to his illness. Cleveland notes that she chose to offer directives during the art therapy sessions since John had the tendency of becoming overwhelmed and constricted during open-ended sessions. Cleveland observes that both drawings were made with pencil, and that the figures are small in relation to the size of the page. In addition, what John describes as *the parasite* was drawn larger than the figure representing the self. For example,

> John's first drawing...depicts 'the disease of eating disorder...it's a parasite with many bones with mouths, with spines, jagged teeth...it sucks the life out of me.' In response to the second directive, he drew 'the parasite...it is larger than me...sucks the life out of me...my identity...who I am...I do things that I know are wrong...it controls me...it sucks the life, the personality out of my brain and heart. (p. 59)

Cleveland follows John's verbalizations by asking, *what supports you?* John added the colors blue and green with colored pencil, which are his favorite colors, representing "wide open spaces and nature" (p. 61). He also drew hands supporting his back, which he stated represented his family. When asked to relate his inpatient work to his life outside the hospital John drew a figure with a circle of bones touching his head, reaching out to another figure. John then began to process the drawing by describing anorexia as "a prison...it keeps me from the relationships I want to have...This is my mother...we're reaching out to each other but the anorexia keeps us apart" (p. 61). Cleveland notes that both figures in the drawing have open mouths and appear angry, although John described the figures as loving towards one another. The author suggests that John may be experiencing underlying anger towards his mother, although this notion seems too threatening to be consciously acknowledged. Since the possibility of negative feelings towards his mother seemed unacceptable to John at this point in therapy, Cleveland opted to suggest exploring what options John may have to change the situation. Under the previous drawing, John added a figure, representing himself, "beating back the illness" (p. 61), and began verbalizing that the figure looked angry. In a later session the art therapist pointed out to the patient that the majority of the figures he drew appeared in profile and were extremely thin. John responded by stating, "I can face myself when I am like that — when I'm too skinny I can't face myself in the same way" (p. 62). Cleveland continued to work with

John until his discharge and encouraged him to share his artwork with his outpatient therapist.

CHAPTER 3: METHODOLOGY

Methodology

Design of the Study

Reports of eating disorders have been increasing since the 1980s, affecting not only young women, but also prepubescent girls, middle-aged women and men. For the purpose of this study, an exploratory qualitative case study design was used in order to address the following research questions: What is the nature of art therapy with the eating disordered male, as seen through the subject? What is the nature of the artwork produced by the eating disordered male, as seen through the subject? The objectives of this case study were to explore the art therapy process with the subject as well as describe the symbolism used in the artwork. Furthermore, the intention was to compare the artwork of the one recruited male eating disordered subjects to females and males with eating disorders who have been previously discussed within art therapy literature. The major features of this study include an examination of the art therapy process and artwork produced, as well as a description of the subject's nature, historical background, physical setting, treatment history, therapeutic process, dynamics, progress and the legal and aesthetic aspects of the cases (Mertens, 2005).

Location of Study

This case study was conducted at the Friends Hospital Eating Disorder Unit, in the northeast section of Philadelphia, PA.

Time Period of Study

After approval from the IRB of Drexel University, this study began January 2007 and ended May 2007.

Enrollment Information

The study allowed for a maximum of three male subjects to be recruited from the Eating Disorder Unit in Friends Hospital, although only one male subject completed the study. The subjects were required to be between the ages of 18 and 60, and were required to receive a diagnosis of anorexia nervosa, bulimia nervosa or eating disorder NOS in order to qualify for this case study. The qualifying subject was diagnosed with anorexia nervosa. Males from all ethnic backgrounds were eligible to be included in the study. The participants were required to be hospitalized for at least one week.

Subject Type

The recruited subject was an anorexic male who hospitalized for inpatient at the Friends Hospital Eating Disorder Unit. The Friends Hospital Eating Disorder Unit is one of a small minority of eating disorder clinics in the Philadelphia area who accept males as inpatients. Therefore, conducting the study at this facility was appropriate in order to have the opportunity to locate qualifying subjects.

Subject Source

All qualifying subjects were admitted to the inpatient Eating Disorder Unit at Friends Hospital.

Recruitment

The researcher trained the psychiatrist, art therapist, family therapist, licensed psychologist, psychology interns and medical director of the Eating Disorder Unit in Friends Hospital of the inclusion criteria of the study so they could refer appropriate patients to the study. When a qualifying individual was admitted that met the inclusion criteria, the author was notified during a treatment team meeting and the potential subject was referred to the researcher for possible inclusion in the study. A trained member of the staff approached the potential subject separately and presented him with an information sheet explaining the purpose of the study, procedures and confidentiality. The information sheet included an invitation to approach the researcher independently in order to participate in the study. When patient approached the researcher, the researcher verbally reviewed the purpose, procedures and confidentiality. Upon agreement of the terms and conditions, the subject signed a consent form and a release of artwork form. The release of artwork form assures the patient's confidentiality, as well as describes the procedure used in this study when storing completed artwork, originals or photographs.

Subject Inclusion Criteria

- The individual is male.
- The individual has received a diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder NOS.
- The individual is over 18 years of age.
- The individual is under the age of 60.
- The patient was hospitalized for at least one week to enable the completion of three individual sessions with the researcher.

Subject Exclusion Criteria

- The individual is female.
- The individual is under the age of 18.
- The individual is over the age of 60.
- The individual was hospitalized for under one week.
- The individual had received a comorbid diagnosis of substance abuse or dependence.
- The individual had received a diagnosis of schizophrenia or psychosis.

Investigational Methods and Procedures

The qualifying individual received one approximately 20-minute session in order to review consent, as well as three individual art therapy sessions over a one-week period. Each individual session was 45 minutes in length and was conducted in a private individual therapy room within the Friends Hospital Eating Disorder Unit. As per the release of artwork form, the patient could choose to keep his original art pieces. In addition, the researcher took a digital photograph of the piece. The digital photograph was transferred to the researcher's computer and burned to a CD. The photograph was then deleted from the researcher's camera, computer and CD after the completion of the research study. All artwork, copies of artwork, CDs and notes were stored in a locked, secure file located in the Hahnemann Creative Arts in Therapy offices.

It should be noted that the researcher facilitated several art therapy groups per week on the Eating Disorder Unit during the course of the study, in which all patients participated. However, these art therapy groups were unrelated to this study,

although group notes of these sessions may be referred to in the discussion section of this study.

Procedures

The first session consisted of the BATES assessment, draw two people doing something in a place. The purpose of giving this directive was to gather information regarding the patient's social functioning upon entering treatment. Anorexics tend to present as socially isolated in their artwork, oftentimes not including even one human figure in their drawings (Waller, 1981). Therefore, by using the BATES assessment, information may be gathered regarding object relationships beyond the simple fact that the patient is isolating his/herself. Furthermore, this assessment acted as a guide for the formulation of goals used in subsequent sessions.

The nature of art therapy is that the objectives emerge through the process of therapy. Consequently, the participant had a unique set of goals, which were explored in the remaining two art therapy sessions. This information was then recorded for the purposes of this study. Furthermore, data was gathered from the participants' charts, art therapy notes, group notes, information given during treatment team meetings, and the artwork produced during each session. Specifically, the data collected included an examination of the art therapy process and artwork produced, as well as a description of the subject's nature, historical background, physical setting, treatment history, therapeutic process, dynamics, progress and the legal and aesthetic aspects of the case (Mertens, 2005). After the last session took place the subject was debriefed of the study and reminded that his individual therapist would continue to be his individual therapist.

Informed Consent (Duration)

The researcher obtained a signature on both consent forms and artwork release forms, leaving one for the participant to keep for his own records and the other was stored in a locked, secure file in the Hahnemann Creative Arts in Therapy offices.

Data Collection

The BATES assessment was administered during the first individual session as a part of this case study. The researcher took detailed notes after the session focusing on the verbal aspects and artwork created during the session. Apart from this first assessment, information was gathered from the subsequent sessions, which were conducted according to the needs and goals of the participant. Again, the researcher took detailed notes focusing on the verbal, behavioral and dynamic aspects and artwork created during each session. Each individual session was 45 minutes in length. Furthermore, data was gathered from the participants' charts, art therapy notes, group notes, and information given during treatment team meetings.

Data Analysis

The artwork and notes produced during the individual art therapy sessions were collected and analyzed by the researcher. The researcher analyzed defense mechanisms, psychosexual stages, color use and line quality of the artwork produced by the subject. Patterns that emerged from both the verbalizations and artwork were based upon the researcher's judgment (Mertens, 2005). The emerging data was examined in relation to information regarding both females and males with eating disorders discussed in the literature review chapter of this thesis.

Possible Risks and Discomforts to Subjects

The possible risks and discomforts included the anxiety that is involved when raising issues during the therapeutic process as well as anxiety associated with the art making during each art therapy session.

Special Precautions to Minimize Risks or Hazards

In order to reduce the anxiety surrounding the creation of artwork, the participant was informed of the purpose and procedures of the study. The participant was notified that their artistic talent and artwork will not be evaluated, but rather that the purpose of creating artwork is to explore the art therapy process with individuals who are male and who have been diagnosed with an eating disorder. Furthermore, the participant was informed that involvement in this study was optional and that the individual was able to remove himself from the study at any time. In addition, the participant was made aware that the confidentiality forms were stored in a locked, secure file in the Hahnemann Creative Arts in Therapy offices. If the participant desired, short breaks during the art therapy sessions were included in order to reduce the subject's anxiety. The subject was also informed that he could be referred to the unit art therapist or other therapists on staff, if necessary. After the last session a debriefing of the study took place, and the subject was reminded that his individual therapist would continue to be his individual therapist.

CHAPTER 4: RESULTS

This section discusses the case of an anorexic male, dubbed Anthony for the purposes of this study, who received inpatient treatment at the Friends Hospital Eating Disorder Unit. As stated in the Methodology section, the study allowed for a maximum of three male subjects between the ages of 18 and 60 to each participate in three 45-minute individual art therapy sessions. Only one male subject qualified for and completed the study. Before beginning this section, the words of Shaverien (1995) should be considered:

> Pictures do not have fixed meanings; their meanings are always multiple. The viewer will inevitably have their own associations to pictures. To avoid the pictures being subject to multiple diverse interpretations, there is a way of limiting the potential meanings and this is to attend to the context. (pp. 60–61)

In this case, the context is such that Anthony and I met three times over a one-week period. Therefore, the therapeutic alliance was only beginning to be established and many of the happenings in the therapy session, as well as the imagery, were affected by this fact. Furthermore, the patient was aware that this study was taking place during the last week of the researcher's internship, which meant that the work done within the context of the individual art therapy sessions would be followed up upon by a different therapist, a psychology intern who took a verbally based approach.

Culture of the Eating Disorder Unit

The Friends Hospital Eating Disorder Unit accepted between 10 and 14 individuals for inpatient treatment at the time of this study. The average length of stay was

approximately two weeks, although this was determined on a case-to-case basis. Factors that influenced length of stay included severity of eating disorder symptoms, how quickly an individual was able to meet and then maintain his or her target weight, health insurance coverage, and the establishment of proper aftercare as determined by the treatment team. The majority of patients received a comorbid diagnosis in addition to their axis I eating disorder diagnosis, such as depression, obsessive compulsive disorder, bipolar disorder, post-traumatic stress disorder, borderline personality disorder, substance abuse or dependance, and Asperger's syndrome.

Patients were predominantly female and their ages ranged from 14 to over 60. In the eight months that the author interned at Friends Hospital, eight males, five of whom were over the age of 18, entered inpatient hospitalization for an eating disorder. Of the five potential candidates, only one male patient qualified and consented for the study after the author had received approval to conduct research by both Drexel University and Friends Hospital.

The patients slept in a locked unit, and walked to the facility where groups and family therapy sessions took place on weekdays. Group therapy included process groups, nutrition groups, cognitive behavioral therapy groups, nursing groups, groups that focused on family issues, a cooking group (every friday afternoon), and art therapy. Art therapy took place four days a week, twice a day. In addition, each patient received individual therapy, which also focused on aftercare issues (with either a psychology extern, intern, psychologist or art therapist) twice a week for 50-minute sessions. Each patient also was entitled to two family therapy sessions per week, if the individual consented to contact with their family.

Demographics

Due to the limited amount of information available from the patient's chart and therapy notes, only a brief history of the present illness along with the family situation could be formulated. Anthony is a 51-year-old single homosexual Caucasian male who was receiving inpatient treatment due to severe dietary restriction and weight loss. Upon admission the patient was 5'10" and 113 lbs. He acknowledged difficulties with concentration, hopelessness, passive suicidal ideation with no history of suicide attempts, social isolation, little interest and hypersomnia, where he slept up to 15 hours a day prior to admission. During his initial assessment with the psychiatrist, the patient presented as neatly dressed and groomed with memory intact. He talked slowly, using normal volume and his mood appeared to be depressed. Furthermore, he was informally assessed to have above average intelligence although he displayed limited insight and judgment in regards to his illness. After this initial assessment, Anthony was given a DSM IV TR Axis I diagnosis of anorexia nervosa and major depressive disorder. Anthony also had a series of medical problems such as neuropathy in his leg, which caused him difficulties with walking, as well as a history of petit mal seizures and osteoporosis. This was Anthony's third inpatient hospitalization, the first occurring at the age of 17 for depression, and the second occurring one year ago due to severe caloric restriction, weight loss and depression. According to the psychiatrist's progress notes Anthony's mood improved and he was able to successfully regain weight during his last admission. This continued upon discharge until his outpatient doctor changed his medication to Lithium and he began experiencing severe fluid retention as a side effect of this new treatment regime. Anthony then stopped taking all medications, which coincided with the deterioration in mood and recommencement of restrictive behaviors.

Anthony is the oldest of seven children, in a family with four brothers and three

sisters. When he was in his late teens or early twenties Anthony began periodically binge eating, perhaps one or two times a year, during "periods of high stress". He would then begin exercising in order to lose the weight he had gained from the binge-eating episode. At the age of 29 he began working and the binge eating ceased. Anthony has a history of over exercising, where he ran between 5–10 miles a day. This behavior was forcibly ended in his early forties when he developed neuropathy in one of his legs, causing both pain and difficulty walking. Anthony stated that he began restricting his dietary intake at approximately the age of 45. Around this same time period Anthony also lost his job and moved back in with his mother (age 77), aunt (78), sister (42) and brother (40), with whom he lived prior to the current hospitalization. His other siblings are married and live in their respective homes. There is a history of depression with his father, paternal grandmother, aunt and brother. Anthony reported that his father also suffered from alcoholism, whereas Anthony denied using alcohol. Furthermore, his brother was diagnosed with agoraphobia. Anthony reported that when he was living independently he was social and was able to maintain relationships, but that he was currently having difficulties remaining social because his old neighborhood, which was predominantly gay, was only accessible to him by a long ride on public transit.

Session 1

As stated in the Methodology section, the first art therapy session consisted of the BATES assessment, draw two people doing something in a place, in order to gather information regarding the patient's social functioning upon entering the inpatient environment. We met in a private room that was usually reserved for family therapy sessions. The room consisted of a number of upholstered chairs that formed a circle, a coffee table, several side tables and a chalkboard. Since the coffee table was low

to the ground, Anthony was offered a large piece of cardboard, which he was able to use as a drawing board. White paper, colored pencils, markers, oil pastels and chalk pastels were placed on the coffee table and were readily available throughout the 45-minute session, although Anthony chose to work only with colored pencil. When the directive was given, Anthony regarded me and asked, "Can it be people walking?" I explained that what he included in his drawing was his choice and that we would be discussing this artwork when he felt comfortable to do so. As he drew Anthony began asking me about my studies. He began describing his interest in English literature and psychology and stated that he too would like to obtain a Masters education. Anthony discussed wanting to relate his experiences to others and "maybe contribute to society... but I guess I first need to get this under control". As Anthony drew I noticed that his hand shook. This seemed to occur whenever he used his hand for fine motor work, for example while writing.

When Anthony finished drawing, he placed the page on the coffee table and began discussing his associations to the artwork. During the processing period Anthony asked several times if I would understand him and if he was making sense. He seemed to be concerned about how clearly he was able to express himself. Anthony explained that the drawing (see Figure 5) contains two stick figures with smiles on their faces standing in what appears to be a valley between two large slanted mountains outlined in purple and filled with green. There is an orange-red sun in the sky, along with slanted light blue birds. One may note that the sky is partially filled in with a darker blue that extends below the mountain area giving it a free-floating effect. Furthermore, the figures seem to be looking in opposite directions and the figures are only partially grounded on the side of the mountain. There is a slight variation in the darkness of the lines that outline the mountain. It would seem as if this variation is due to the texture of the cardboard Anthony was using as a drawing board.

The patient's associations were as follows: The two figures in the drawing are looking at the mountains. They are marveling and enjoying nature. They are in a reflective state regarding their past with the eating disorder and are marveling on how far they have come. Anthony equated this drawing to his struggle with his eating disorder and stated, "an eating disorder is all about a lack of self-acceptance". He described it as a sort of journey and stated that the two figures had made it up one mountain and were resting and contemplating going over the next. They are aware that they must go over the next mountain, but they are choosing to stay in a reflective state between the mountains. The two figures are "supporting each other". He then began expressing that he feared giving up his restrictive behaviors and going through treatment for a second time, although his eating disorder had "taken away" so much. For example, he acknowledged that the eating disorder had caused him to lose time and deprived him of "potential relationships" as well as negatively affecting his "clarity in thinking". Anthony went on to discuss his embarrassment that he is living at home with his mother and that he was laid off from his job seven years ago without being able to find another one. He stated that he wants to work, and stated that working gives him "less time to focus on myself". He agreed that perhaps volunteer work would be a helpful addition to his aftercare plan. As the conversation continued, Anthony stated that he was upset with being back in treatment although he needs to realize that the "perfect body isn't skin and bones". As the session concluded, Anthony expressed difficulty with being the only male patient on the eating disorder unit. He asked if he could receive individual treatment by a male psychologist who was a part of the treatment team, rather than working with two young female interns. I replied by explaining that the psychiatrist and the treatment team had assigned him to both therapists and that he could raise his concern with the treatment team. I also acknowledged both our gender and age differences. Although my comments seemed

to appease him for the moment, this subject would reveal itself once more during the course of our work together.

Case Notes Session 1

DATA: Met with [Anthony] individually for art therapy session. Directive was given "draw two people doing something in a place". [Anthony] created a drawing with stick two figures between two large mountains – and stated that these individuals are looking at the mountains and marveling about nature – enjoying nature – as well as [contemplating] how far they had come. He equated this drawing to his struggle with his eating disorder and expressed fears regarding giving up his symptoms. Patient was able to describe what "the eating disorder has taken away" – "potential relationships" and has negatively affected his "clarity in thinking". [Anthony] went on to discuss his embarrassment that he is living at home with his mother and that he was laid off from his job seven years ago, and still hasn't found another one. He stated that he is in contact with [a job seeking service]. I suggested that in the meanwhile, perhaps he would be interested in doing volunteer work since "giving back" and "making a difference" is meaningful to him. [Anthony] agreed this would be helpful and gave some of his interests in regards to volunteer work – adults, hospital setting.

ASSESSMENT: [Anthony] seems willing to make changes in his structure outside the hospital that would support him in remaining compliant with treatment goals. Evidence of organicity in artwork – perhaps due to seizures or medications – his hands shake as he draws/writes.

PLAN: Will follow up with [Anthony] tomorrow and discuss coping skills.

Figure 5: Anthony session 1

Session 2

The second session took place one day after the first, this time in the art therapy room. Although there was an abundance of materials available in the room, only pencils, markers, oil pastels and chalk pastels were on the table, along with white paper. Artwork from a group that had taken place earlier in the day was on the table as well, although because the table was large enough for approximately 15 people, this did not seem to impair Anthony's ability to create. However, because Anthony could see the artwork from the previous group, it is possible that he may have been influenced by this while creating artwork in the second session. In addition, before entering the session I observed that the psychiatrist had noted a rapid increase in the patient's weight since the previous day due to fluid retention, a common occurrence during the re-feeding process.

This session began with Anthony sitting down to my left, turning his chair towards me and stating that he no longer wants to be in the hospital and that he was contemplating signing himself out from treatment. I asked if he could express what it is like to be in treatment, but this time to refrain from using stick figures. Anthony responded by turning towards the table and quietly using colored pencil, marker and chalk pastel to render his second drawing, shown in Figure 6. Once the drawing was completed, Anthony began by stating that the frowning brown figure represented himself and that the pink enclosure represented the hospital. There are three pink figures on the left side of the figure and two to the right. The sun is included in this drawing on the upper right hand corner of the page. Anthony stated that he chose the color pink purposefully to depict the hospital and the figures that are standing next to him because he was finding it difficult to make connections with the young women on the unit, both staff and patients. He continued by saying that he "should be able to do this on my own" and described feelings of confinement due to the in-

patient setting. I responded by describing my clinical observation that oftentimes eating disorder patients leave treatment before they are ready, although they may feel like they are ready. I pointed out that eating disorders may be deceptive in that way, and that although he may not agree, extra support can be helpful in combating the illness. After a moment of silence Anthony responded by describing fearfulness of an upcoming family therapy session to which he had consented the previous day. He stated that he was "afraid of stirring things up too much" and being blamed for this. He expressed concern for his mother, who, as stated previously, is 77 years old, which is why according to Anthony, his home situation was not likely to change. When asked if he could verbally or visually describe this situation Anthony seemed to become agitated and explained that it was "unpleasant". He also admitted that he was isolating himself from his family and stated that a male friend who he considered a primary source of support had not returned his phone calls in weeks. It should be noted that after this session, Anthony asked the family therapist to cancel his upcoming appointment.

Case Notes Session 2

DATA: Met with patient individually for art therapy session. [Anthony] began this session by stating that he does not want to be in the hospital – asked to draw what it is like being in treatment – drew self in the hospital. The patient stated that he drew the people surrounding him and the hospital in pink because he is finding it difficult to make connections with the young women (staff and patients). Also stated that he feels he should be able to do this on his own. I educated him regarding how oftentimes patients with eating disorders leave before they are ready and that just because he is feeling better does not mean he does not need extra support currently. Patient also spoke of fears regarding family therapy – fearful of "stirring things up

too much" and being blamed – protective of mother and doesn't think the family situation is changeable – although he refuses to describe (either verbally or visually) what this situation is like beyond saying that it's "unpleasant" and that he has been isolating himself from his family. Patient also discussed how his friend [Tom] used to be a support but has not returned his phone calls for several weeks (he called three weeks ago).

ASSESSMENT: Patient seems to be having difficulty accepting reduced autonomy when in the hospital – autonomy in the family seems to be a key issue as well. For this reason volunteer work was suggested and discussed. Based on his verbalizations describing an appreciation for books, art and wanting to work in a hospital setting, I gave [Anthony] information for volunteer work at the public library, the art museum and [a residential home for the mentally handicapped]. Encouraged patient to begin journaling.

PLAN: Follow up with [Anthony] on Friday for final individual art therapy session.

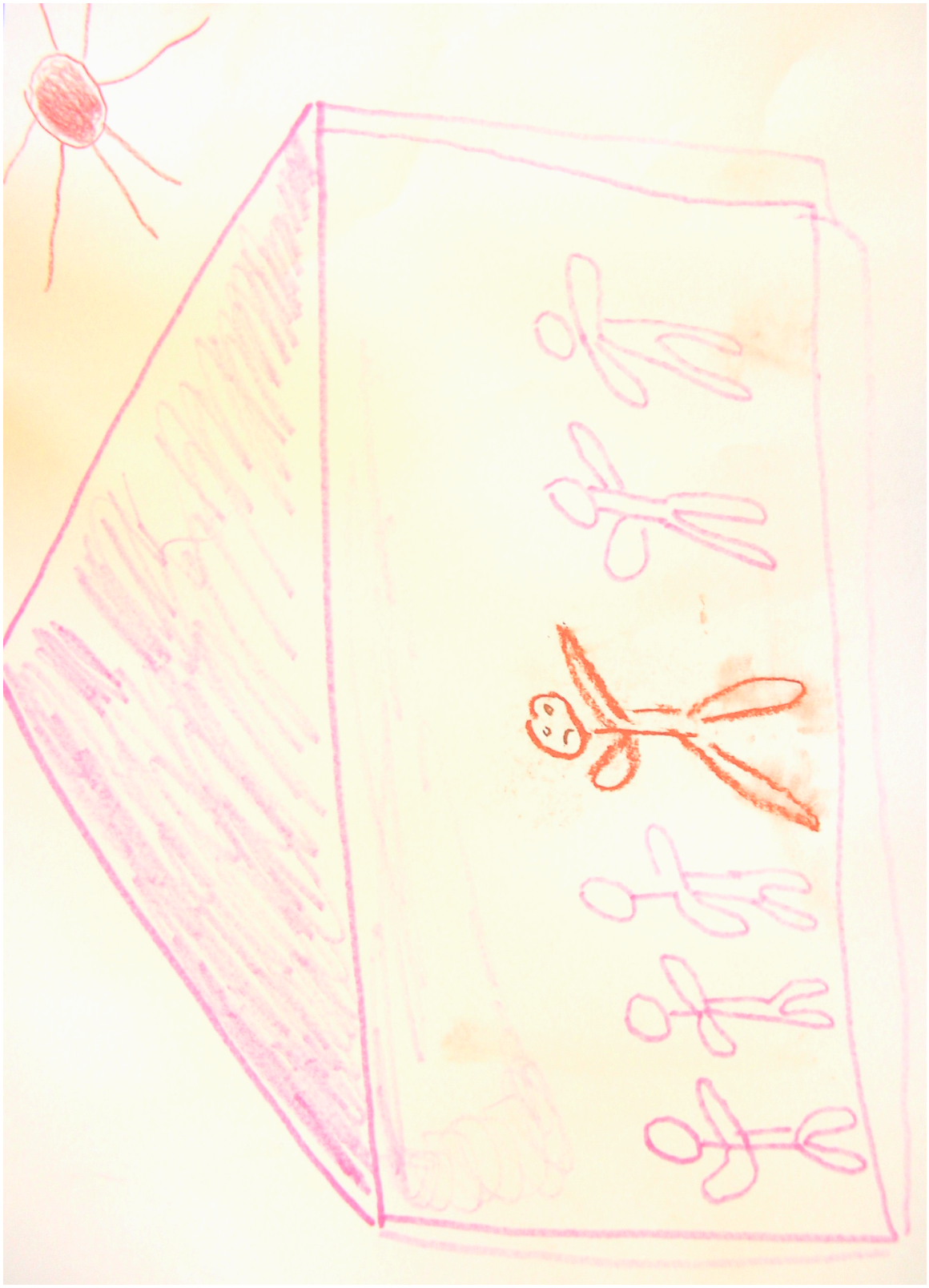

Figure 6: Anthony session 2

Session 3

The last session took place three days after the second session, which was also my last day of an eight-month internship. The psychiatrist noted in the patient's chart that Anthony had gained 14 lbs in five days due to fluid retention. The third session began with a brief discussion regarding Anthony's family and history of present illness, which is included in the beginning paragraphs of this chapter. During this conversation Anthony explained that although he primarily identified as homosexual and that his family was aware of this, he was questioning his sexuality. He stated that the idea of heterosexuality was more acceptable to him. After a moment of silence, Anthony turned to me and asked who on the treatment team would be privy to information relayed during an individual therapy session. I responded by telling him who attended the treatment team meetings: therapists, interns, nurses, the director of the Eating Disorder Unit and the psychiatrist. In addition, I noted that all staff members, including the technicians, have access to patient files and I reminded him of the fact that he was participating in a case study for a Masters thesis. Anthony became quiet and explained that there was an "incident" that happened in the past for which he feels "somewhat responsible", and that he had discussed the issue with previous therapists. He indicated that one past therapist had maintained that "the incident" was not his fault, while another therapist told him that he did harbor some responsibility for what had happened. Anthony explained that discussing this topic brings pain, guilt and shame, which is why he was not sure if he wanted to share the incident with the staff at Friends. However, he also acknowledged that the incident needed to be addressed in a therapeutic context as it may be tied in with his eating disorder pathology. I asked if he could visually express the experience of secrecy in relation to his eating disorder, the result of which is shown in Figure 7. Please note that the black square in the lower right corner of the image was placed to obscure

the patient's real name.

Anthony used both colored pencils and markers to create his last drawing. Here we see an orange sun on the upper right hand corner, slanted birds of a variety of colors in the sky and a black rectangle on the bottom mid section of the page, which Anthony explained represents a waterhole. Anthony described himself as being inside the waterhole where he is "stuck because of guilt". He explained that nature surrounds the waterhole, the birds representing people who are "striving to soar in life". However, "I'll forever be looking at life in the watering hole...I'll never be able to reach out...I'll never be able to enjoy life...not coping with your past means you have no present". Anthony went on to say that the watering hole represents his eating disorder, and that because he is trapped inside he is "only taking in enough to survive...only a mouthful of water here and there...above ground there is food and water...I can only go above ground once in a while".

As the session ended, I summarized the events of three art therapy sessions and reminded him that this would be the last day we would be working together. To my knowledge Anthony kept his artwork and similar to Naitove (1986) and Makin (2000), I encouraged him use creative journaling as a way of exploring and coping as he progressed through treatment.

Case Notes Session 3

DATA: Met with [Anthony] individually. He spoke of being reluctant to discuss with therapist an incident that occurred when he was young – afraid of staff judging him and is debating whether to trust therapists on unit. Patient discussed how the incident in question had been brought up with his outpatient therapist a few months ago and expressed understanding that this past incident may be connected with eating disorder behavior. Patient created artwork about what it is like to keep this incident

a secret. Imagery indicated isolation, anxiety, and he discussed the connection with not coping with the past and difficulties living in the present. Patient also discussed the fact that he is presently questioning his sexuality – has identified himself as a homosexual for approximately 30+ years, but is currently questioning whether he is truly attracted to the same sex – he discussed heterosexuality as being more acceptable to him.

ASSESSMENT: Patient presents less depressed than previous sessions – maintaining eye contact with therapist, facing therapist. It seems that homosexuality is unacceptable to the patient. Furthermore, regarding his anxiety with sharing the past incident with staff – I assured him of staff professionalism.

PLAN: Patient will continue individual sessions with the psychology extern.

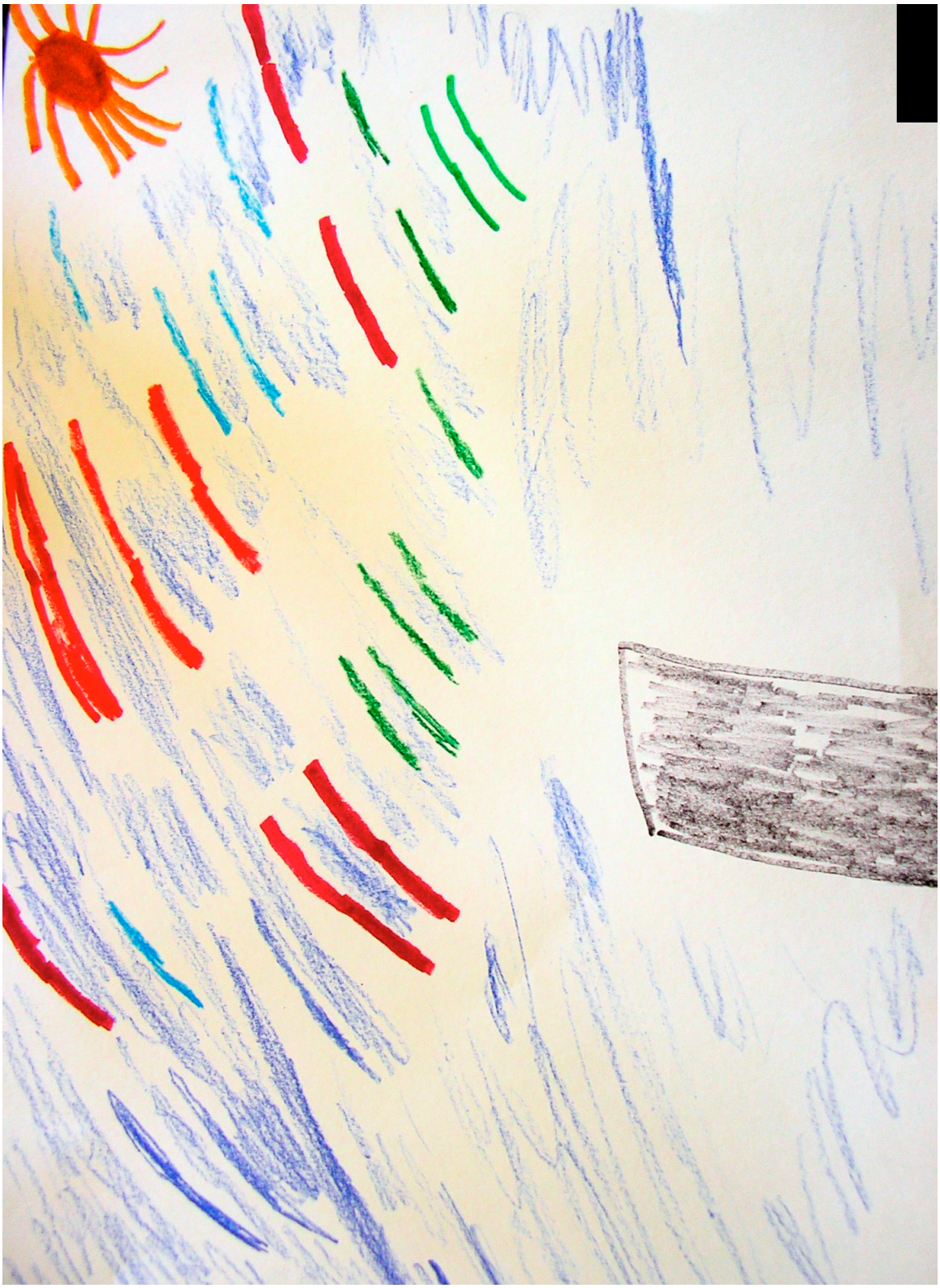

Figure 7: Anthony session 3

CHAPTER 5: DISCUSSION

Overview

As stated in the Results chapter, one male subject qualified and completed the study. In this chapter, similarities between Anthony's clinical presentation and the reviewed literature in Chapter 2 will be discussed. Although repetitive patterns and symbolism had little time to emerge in this case study, images commonly found in the art therapy literature will be discussed in relation to this case. Color use and line quality will also be compared to the literature found within the subsections entitled The Artwork of Eating Disordered Patients and Art Therapy and Men with Eating Disorders. This chapter will also examine the developmental level, defense mechanisms, and psychosexual stages represented in the artwork according to the theories of both Lowenfeld & Brittain (1982) and Levick (1983). As with all artwork, the content includes multiple meanings (Shaverien, 1995); consequently, for the purposes of this study meaning will be extracted through the careful examination of both the imagery and the verbal associations made by the patient. It should be noted that due to the short duration of the study consisting of only three drawings created over a one-week period, generalizations may not be made. Rather the intention of this case study is to add to the existing body of literature regarding art therapy and men with eating disorders, as well as to record the nature of the art therapy process and artwork produced, including its symbolism and verbal processing.

As indicated in the literature, most eating disorders tend to develop in adolescence or early twenties (Sadock & Sadock, 2003). In contrast, Anthony was diagnosed with anorexia nervosa at the age of 50, although he had a history of binge eating and over-exercising beginning in his youth. The question remains whether his eating

pathology may have been diagnosable in his adolescence or early twenties. Harris & Cumella (2006) point out that this clinical presentation is common amongst those with late onset eating disorders. In fact, Anthony's presentation is similar to the case of a 62-year-old bulimic male discussed by Morgan & Marsh (2006) in the subsection entitled Men and Eating Disorders: An Overview. For example, both patients began exhibiting eating disorder symptoms several years prior to receiving a diagnosis and both presented with a history of over-exercise behavior that was forcibly ended due to a physical injury. According to Schmidt et al. (1997), significant life stressors may trigger eating disordered behavior later in life. In the case of Anthony, one may hypothesize that losing his job, moving back in with his mother, and developing neuropathy in one of his legs may have all contributed to the late development of anorexia nervosa. Anthony also alluded to an incident that occurred when he was young in which he may have been abused. As stated previously abuse has been cited as a risk factor for the development of an eating disorder (Sadock & Sadock, 2003).

Sexual Identity

Homosexuality and difficulties with sexual identity are considered risk factors for the development of eating disorders in males (Harris & Cumella, 2006). As stated in the previous section, Anthony identified as a homosexual, although he seemed to have trouble accepting this part of himself and stated that he considered heterosexuality a more reasonable way to live one's life. Since anorexia is thought to express a denial of one's sexuality (Sadock & Sadock, 2003), it may be hypothesized that Anthony feels conflicted about with his sexual orientation, and perhaps rejects this aspect of himself. Indeed, throughout his artwork, the human figures lack any means of distinguishing man from woman, except in Figure 6, where he used the color pink to indicate both figures and places that he considered feminine. Lubbers (1991) noted

that the inclusion of asexual figures is a common feature in the artwork of anorexic females. Anthony therefore presents in a similar fashion as females in that he seems to be struggling with his sexual identity, albeit a male homosexual identity.

Resistance to Art Making

Oftentimes, the art therapy process can help identify both the underlying strengths and areas of difficulty of the patient. For example, several researchers describe resistance to the art making process during their first meetings with anorexic patients, which may be due a need for control or an obsession regarding making the perfect picture (Rehavia-Hanauer, 2003). Anthony seemed to have little difficulty beginning the art making process, although in the first session he did appear to ask for reassurance that there were no expectations as to how he should interpret the directive. Asking for reassurance during the initial art therapy session may have occurred due to the fact that making artwork in front of other individuals can be anxiety-provoking, especially when the art making takes place in front of a therapist the patient had only met a few days prior.

Comparison to Anorexic Artwork

Rehavia-Hanauer (2003) points out that "the need for complete control and the feeling of lack of control" (p. 142) may be present in the artwork and may be expressed through the patient's choosing to work with structured media, such as colored pencils and markers. Indeed, the majority of Anthony's artwork was made with colored pencils and markers. However it should be noted that Anthony mixed media in his artwork, which is uncommon for anorexics (Makin, 2000). Anthony also drew himself using chalk pastel in Figure 6, which Makin considered to be more favorable to anorexics, although this art material is considered in the middle of the media con-

tinuum — more structured than paint, but less structured than pencil or markers. In addition, Anthony uses a variety of colors in his artwork and his drawings take up the whole page, whereas the literature has stated that anorexics initially minimize their color use and create small, controlled, detailed drawings (Makin, 2000) with a light line quality (Lubbers, 1991). In this way, Anthony's artwork seems uncharacteristic of restrictive anorexics. The patient's history of binge eating behavior in his twenties may be indicative of impulsive behavior patterns, which may provide an explanation and parallel the somewhat hurried line quality and ample color use. It is possible that Anthony uses restrictive and controlled behavior as a way to defend against impulsivity. It is equally possible that the line quality is a result of anxiety, perhaps due to his return to inpatient treatment or participation in a case study. Regardless, when considering his variable media choices and spontaneous line quality, one may hypothesize that Anthony is perhaps more open to treatment in comparison to other anorexic female and male patients who enter inpatient treatment, such as the ones discussed in the subsections entitled The Artwork of Eating Disordered Patients and Art Therapy and Men with Eating Disorders.

BATES

The first art therapy session, which resulted in Figure 5, consisted of the BATES assessment, *draw two people doing something in a place.* The purpose of giving this directive was to gather information regarding the patient's social functioning upon entering treatment. Anorexics tend to present as socially isolated in their artwork, oftentimes not including even one human figure in their drawings (Waller, 1981). Therefore, by using the BATES assessment, information may be gathered regarding object relationships beyond the simple fact that the patient is isolating his/herself.

Upon first glance, Figure 5 seems pleasant (without drama or conflict), with two

smiling figures, which is common in drawings made by anorexics (Mitchell, 1980). Referring to Figure 5, Anthony described a journey through mountains, where the two companions were "supporting each other" and in a reflective place between to mountains. They were contemplating where they had been and whether they would continue on their way. The image of mountain climbing was described by Makin (2000) as a common metaphor used to represent the journey towards recovery. In the case of Carlos, Shaverien (1995) commented that the patient's artwork seemed to imply a spiritual journey in relation to the recovery process. One may hypothesize, therefore, that Figure 5 may symbolize Anthony's struggle to accept inpatient treatment (the first mountain), and the struggle with the decision of whether to continue with treatment (the second mountain).

It is interesting that Anthony described the two figures as supporting one another since they are both standing on different mountains and are not looking at each other. This may express the dichotomy in the dynamics of eating disordered patients, where although there is a desire to connect with others there is also a fear of intrusion (Rust, 1995). This may correspond to what Rehavia-Hanauer (2003) describes as a common conflict of anorexia, where one wishes to be both dependent and independent in object relationships. Since this drawing includes two people, paralleling the two people present for the creation of the drawing (patient and therapist), it is possible that a transferential relationship is being symbolically expressed. Perhaps there is a wish for a supportive relationship — one that does not involve an intrusion across one another's boundaries. In addition, since the two figures seem to be avoiding each other's gaze, resistance to the development of a therapeutic relationship is perhaps being expressed.

When processing Figure 5, Anthony expressed a desire to stay in the valley for the time being. The metaphor of the valley may correspond to the conflict described

by Rehavia-Hanauer (2003) as "the desire and need to be looked after and held and the verbal inability to directly express this need" (p. 142). The valley may be viewed as a holding environment between the decision to receive inpatient treatment and contemplating the next hurdle, or mountain: choosing to remain and comply with treatment. Furthermore, mountains are thought to represent mother or nurturance. Anthony may therefore be expressing his need for a holding environment until he has made his decision. Anthony connected the mountains to his eating disorder and spoke of several ways that the eating disorder had negatively affected his life. For example, he explained that it deprived him of "potential relationships" and "clarity in thinking". He also spoke of losing his job, living with his mother, yet wanting to "contribute to society". Despite this, however, it seemed as if that Anthony was still unsure whether he was willing to continue treatment.

Body Image

During the first session, Anthony mentioned what may be a clue to his body image, that he should learn that a "perfect body isn't skin and bones". Other indications of body image may be present in Figure 5. For example, the two people were portrayed as stick figures, which seem to resemble "skin and bones". As stated previously, the figures seem asexual and lack details or distinguishing features from one another. It is possible that the stick figures were included as a sort of shorthand for the human figure. However, as will be discussed below, the directive in session two included the added request to not include stick figures in order to gain insight regarding the patient's body image. Indeed, the bodies of the people in Figure 6 are fuller than in Figure 5, but still lack detail and distinctive features, suggesting perhaps that the body is being denied and/or rejected by Anthony. In addition, the individuals depicted in Figure 5 lack both hands and feet, perhaps indicating a difficulty with

independence and coping with the environment.

Developmental Levels

Artwork may be interpreted developmentally and has been studied by several scholars including Lowenfeld & Brittain (1982). Lowenfeld & Brittain examined the way children develop artistically throughout childhood and adolescence. The author identified six stages of development, which commonly correspond to specific ages. Only the first three stages will be summarized here due to their relevance in the analysis of this case study. The first stage is entitled the scribble stage, which usually occurs between the ages of two and four. It is characterized initially by mark making for kinesthetic purposes, which later develops into drawing shapes to represent people, places or things, as well as story telling. The pre-schematic stage usually occurs between the ages of four and seven years old. Scribbles and shapes give way to recognizable objects whose schemas are flexible, although figures still tend to float on the page with no ground line. The composition of the drawing tends to be egocentric, where, for example, a figure representing the self will be in the middle of the page. A figure may have a social smile on the face, indicating the child's growing awareness of the social environment. Distorted and omitted body parts are common, and colors are chosen in relation to emotions rather than reality. The third stage of artistic development is the schematic stage, which commonly occurs between the ages of seven and nine. Here, schemas are consistently repeated in the artwork, where, for example a person or a flower will be drawn in a similar fashion. The schema is only altered when special meaning is being conveyed. Drawings are meant to display concept rather than percept and often reflect the child's knowledge of the environment. A baseline and skyline are often present in schematic drawings. Objects are represented two-dimensionally and appear flat. X-ray drawings are also commonly observed in this

stage, where the viewer can see inside otherwise opaque environments. For example, a house and the inside of a house may be drawn simultaneously.

Levick

In her book, *They could not talk and so they drew*, Levick (1983) connects the psychosexual stages proposed by psychodynamic theory with Piaget's cognitive theory. Levick also posits that developmental level corresponds to the defense mechanisms used in relation to the self and the environment (see the subsection entitled Developmental Issues). Levick was primarily concerned with uniting art therapy theory with psychodynamic theory, cognitive theory, and artistic developmental level. Levick believed that through observation of patient artwork and verbalizations, the art therapist may be able to gather detailed information regarding the patient's emotional, cognitive, and defensive states more efficiently, than would be possible using other means. By combining Levick's work with that of Lowenfeld & Brittain, a comprehensive understanding of patient artwork comes into focus, which will be used through out this chapter to analyze Anthony's artwork.

Psychodynamic Stages

The literature in Chapter 2 examined psychodynamic theory, which suggest that difficulties surrounding early nurturance (the oral phase, zero to two years of age), and the separation and individuation phase (the anal phase, two two three years of age) underlie the psyches of individuals who suffer from anorexia. Family issues have also been identified as underlying the development of an eating disorder, which would correspond to the phallic phase, where the oedipal phase takes place (ages three to six). The oral, anal and phallic phases correspond to Piaget's sensorimotor (ages zero to two) and preoperational stages of thought (ages two to seven). The

latency phase of development (age seven to the onset of puberty) corresponds with Piaget's concrete operation stage (ages seven to eleven). As stated above, Lowenfeld & Brittain's (1982) scribble stage typically occurs between the ages of two and four, while the pre-schematic stage usually occurs between the ages of two and seven. The schematic stage occurs between the ages of seven and nine.

Correlation of Stages

When these theories are correlated, the oral, anal and phallic phases take place during the sensorimotor and the preoperational stages of cognition, which simultaneously correspond to the scribble and pre-schematic stages of drawing development. The latency phase takes place during the concrete operational period, as well as the schematic phase. According to Levick (1983), elements of all previous drawing levels and therefore defenses and unresolved conflicts will appear even if the individual is primarily drawing on a higher level. One might therefore expect that if an individual created artwork that corresponded, for example, to the schematic stage, their defense mechanisms and conflicts would likely correspond to the latent phase, as well as the anal and phallic phases. Furthermore, the individual would cognitively likely be on a concrete operational level.

Figure 5

In Figure 5, one may note that the visual composition seems to correspond to both Lowenfeld & Brittain's (1982) pre-schematic and schematic stage. The mountains seem grounded, which is an element of schematic drawings, while the color use is only partially based in reality and the figures are missing body parts, such as hands and feet, corresponding to pre-schematic elements. There also seems to be a social smile present on the faces of the people depicted in this drawing. One may further

observe that the two figures are not looking directly at each other, which may be interpreted as the defense of avoidance. Specifically, it seems that the patient may use this defense mechanism to relate to other people, which may be connected to the social isolation depicted in the subsequent two drawings. Denial, or more specifically denial of the body, may be seen in Anthony's use of the stick figure, which as stated previously may relate to the clinical observation that anorexics tend to deny the body and sexuality (Lubbers, 1991; Sadock & Sadock, 2003). One may also observe that the drawing seems as if it could be divided symmetrically down its center. This may represent the defense mechanism of splitting, which could be said to correlate to the previously discussed conflict whereby Anthony may be having difficulty integrating unacceptable aspects of the self, for example his homosexual identity.

Figure 6

The second session began with Anthony stating that he was considering leaving the inpatient treatment setting, which he had also seemed to imply with his associations to Figure 5 during the first session. Upon drawing and processing Figure 6, Anthony described two possible reasons for wanting to terminate therapy. Firstly, he drew a pink hospital with pink people surrounding a brown figure representing himself. Anthony stated that he was having difficulty adjusting to the young females, which comprised most of the patients and staff on the eating disorder unit. Second, as processing continued Anthony described anxiety surrounding an upcoming family therapy session. One may also hypothesize that another dynamic may have been at play, where the rapid increase of fluid retention may have caused changes with his physical attributes raising his anxiety regarding treatment.

Although the mother figure does not seem to appear directly in Figure 6, it is possible that this drawing may represent the transference Anthony may be experiencing

in relation to the female patients, staff and his mother. For example, he discussed wanting to leave therapy due to what may be described as a struggle with femininity, which later manifested as verbalizations regarding his mother. Shaverien (1995) points out that the development of transference between the patient and therapist where the therapist represents mother can be an important step in recovery. One may suspect that had the art therapy sessions continued, the relationship between the self, home, femininity, community and the therapeutic setting would have become clearer and more easily interpretable.

It will be recalled that Luzzatto's (1995) theory of the mental double trap consists of three basic elements: the self, the prison and the persecutor. In most cases the self is trapped inside a prison, which is simultaneously restricting the self from the world and protecting the self from the persecutor. Variations on this theme are proposed, for example where the prison and persecutor merge (see the subsection entitled The Artwork of Eating Disordered Patients). Figure 6 seems to correspond to this variation, where the hospital (prison) and the female/mother image have merged, entrapping Anthony inside. This dynamic also seems similar to the "mum tree" drawing discussed in the case study of Carlos (Shaverien, 1995). For example, the "mum tree" included a sphere (representing the self) that was located in the center of the tree, representing Carlos' mother. In the case of Anthony, femininity seems to be holding the self in the center of the page. Although his mother is not directly included in the drawing, the fact that Anthony began discussing his mother later while processing Figure 6 may indicate that both femininity and mother may be intertwined and symbolized as a protecting and a persecutory figure simultaneously.

Similar to Figure 5, the imagery in Figure 6 includes figures that are indistinguishable from one another, except for the color choice, which Anthony had mentioned was intentional — pink was chosen to indicate femininity. Brown, therefore, seems to de-

pict masculinity. As stated previously, color choices that are idiosyncratic and based on feeling rather than reality are indicative of the pre-schematic stage of artistic development. It is possible that depicting the male figure in brown using a different media choice is indicative of the defense mechanism isolation of affect. Through these choices perhaps the patient was attempting to place emphasis on the self and on masculinity. The brown figure differs from the other figures in its size, color and detail. One may hypothesize that isolation is a defense mechanism Anthony uses in social situations, indicating poor object relationships. Furthermore, the pink figures have no facial features, in contrast to the frown on the face of the brown figure in the middle of the page. In addition, all figures lack hands and feet. The omission of body parts and an egocentric composition are also common elements within the pre-schematic stage. This may correspond to the defense of denial, or more specifically denial of the body, as well as difficulties in coping with one's environment. Similar to Figure 5, the bodies of the people in Figure 6 seem to lack substance, perhaps suggesting a distorted body image and an impaired relationship with the body. Figure 6 is an example of an x-ray drawing, which is commonly seen in schematic drawings. Lastly, one may note an emphasis given to the top of the house-like structure, where the roof is colored in. It has been said that all elements within a drawing represent the self, similar to dreams (Shaverien, 1995). If the house represents the self, the roof would correspond to the head, perhaps suggesting that Anthony is experiencing high amounts of emotional and cognitive activity. For example, he may be primarily "in his head" or "lost in thought".

Figure 7

During the last session Anthony revealed the possibility of a history of abuse in his childhood or adolescence. He seemed concerned about who would be made

aware of this information and explained that he often experienced emotional pain, guilt and shame when discussing the subject. Anthony was asked to visually express the experience of secrecy in relation to his eating disorder, which resulted in the creation of Figure 7. Anthony described himself as being inside a watering hole that is surrounded by nature. This may correspond to the conflict described by Rehavia-Hanauer (2003) as "the desire and need to be looked after and held and the verbal inability to directly express this need". For example, the watering hole may be viewed as a holding environment, one that both contains and imprisons. Luzzatto (1995) describes a variation on her concept of the mental double trap, where the self is inside the prison, but instead of a persecutory object outside the prison, there is an unreachable good object (see Figure 4). One may therefore hypothesize that Figure 7 corresponds to this variation on the mental double trap, where the self is inside the water hole (prison), while nature (the good object) remains out of reach. This idea is supported by Anthony's verbalizations while processing the artwork. He explained that the birds represent people who are "striving to soar in life". He went on to say, "I'll forever be looking at life in the watering hole...I'll never be able to reach out...I'll never be able to enjoy life". Furthermore, Anthony stated that the watering hole represents his eating disorder. One may therefore hypothesize that the eating disorder may serve the dual function of being both a psychic oppressor while also providing a holding environment, albeit a stagnant one. It is possible that difficulties integrating the "incident" into the psyche have produced a schema where psychic imprisonment, persecution, and unattainable good objects are predominant.

In terms of cognition, the preoperational stage is characterized by thinking and reasoning that is intuitive, along with a "sense of 'immanent justice' — punishment for bad deeds is unavoidable", "egocentrism" and "'phenomenalistic causality' — events that occur together are thought to cause one another" (Sadock & Sadock, 2003, p. 28).

One may hypothesize that these cognitive features are present in Anthony's thinking process. For example, the sense of immanent justice may underlie his verbalizations where he seems to believe that the good object, or a positive outcome in life, is not possible. Furthermore, Anthony described believing that his eating disorder may be related to the "incident", for which he felt he may have been partially responsible. Anthony also described questioning his sexuality due to his belief that heterosexuality is more acceptable than homosexuality. It is possible, then, that Anthony believes that he will always be punished for both the incident and the fact that he is homosexual.

If one observes Figure 7 without the knowledge that the black rectangle was meant to represent a watering hole, the shape might be said to resemble a door. This may connect to the symbol of a door described in the case study of Carlos, where a fearful animal was drawn in the process of opening a door. Shaverien (1995) correlated this metaphor with the initial exploration of long repressed unconscious material. If it is the case that the watering hole represents the unconscious, one may then hypothesize that the "incident", along with all that is emotionally and cognitively tied in with it, may be denied, keeping it from reaching consciousness. For example, while Anthony processed his artwork he described being trapped inside the watering hole and was "only taking in enough to survive...only a mouthful of water here and there...above ground there is food and water...I can only go above ground once in a while". One may recall the directive was to *visually express the experience of secrecy in relation to his eating disorder*. Therefore, Anthony's description of "only taking in enough water to survive" when he is in the watering hole, may in fact be a metaphor for what happens when emotions, thoughts, or memories are kept secret. In other words, it is possible that Anthony restricts his dietary intake to the point of mere survival when certain aspects of himself and his experiences are denied. As discussed previously, denial may have been portrayed throughout the first two figures, as well as the third.

In Figure 7, denial was perhaps represented through the denial of the body, where the human figure identified as the self is not visually included in the drawing. However, Anthony continued by explaining that, "above ground there is food and water...I can only go above ground once in a while". One may hypothesize that when Anthony is above ground, or when denied emotions, thoughts or memories are acknowledged and accepted consciously, his symptoms may subside to the point that he is able to take in more than just water, but food as well.

As discussed previously, other possible denied aspects of himself and experiences beyond the "incident" may include his sexual identity, his relationship to his mother and his conceptualization of femininity and masculinity. Therefore, one may hypothesize that if therapy had continued, the exploration of the "incident", homosexuality, family and gender would have been important in Anthony's recovery process. The patient would have been encouraged to visually express denied emotions as well as unacceptable aspects of the self.

Organicity

When viewing the three drawings together, one may notice similarities in the manner in which the images are drawn. For example, in each drawing the content is tilted to the right. This is especially noticeable in the way the birds were drawn. Furthermore, if one observes the shapes, one may notice that overshoots and undershoots are present, where many of the circles and rectangle shapes are not closed properly and the lines either do not intersect or overlap onto one another. Perhaps the most obvious examples are present in the drawings of the figures and the hospital (Figure 6). Tilts, rotations, overshoots and undershoots are considered indicators of an underlying organic neurological problem. These visual markers have also been linked with symptoms such as difficulties with comprehension (Cronin & Werblowsky, 1979),

which Anthony expressed concern about in the first session. However, it should be noted that the possible organic markers discussed in relation to Anthony's artwork seem more subtle than the artwork of someone who had sustained a gross brain injury. Certain indicators of organicity are not present in Anthony's artwork, such as buzz-like line quality, short picky lines, and severe perceptual rotations (Cronin & Werblowsky, 1979). It is possible that medication could produce subtle organic qualities in the artwork. However, Anthony was not taking any medication when he entered inpatient treatment approximately six days prior to the first art therapy session. Furthermore, one may recall from Chapter 4 that Anthony spoke slowly and his hands shook as he made marks on the page. Taken together one may hypothesize that perhaps Anthony was experiencing slight neurological deficits which may be affecting his cognitive, emotional and behavioral functioning in a subtle way.

The possible organicity observed may have originated from one or more aspects of Anthony's medical history and restricting behaviors. For example, the patient has a history of petit mal seizures, which are marked by an absence of muscle spasms and are commonly called "absence seizures" for this reason. Research indicates that absence seizures typically do not damage the brain. However, one subtype of this seizure, called Complex Partial Status Epilepticus may lead to neurological problems, although more research is needed to confirm this possibility (Young & Jordan, 1998; Aminoff, 1998). Anthony's petit mal seizures were being managed by medication, Depakote, combined with Prozac in order to treat his depressive symptoms. It is a possibility that the organicity viewed within the artwork may be related to these medications. Additionally, mild cognitive disorder and loss of brain mass has been observed in anorexics (Sadock & Sadock, 2003). Although brain size has been shown to return to normal after restricting behavior has ceased, Harris & Cumella (2006) point out that permanent neurological damage may have still occurred. Given this

evidence, it would be interesting to observe Anthony's work over an extended period of time in order to examine whether these organic indicators decline the re-feeding process continues.

Analysis of Art Work –Table

Figure:	**5**	**6**	**7**
Content:	· Stick figures · Social smile · Figures have no hands/feet	· Figures have no hands/feet · Figures are faceless (except brown figure) · Body has no substance	· No people · Content is concentrated in the sky
Conflicts:	· Desire to be held (Rehavia-Hanauer, 2003) · Distorted body image ("skin and bones")	· Mental double trap (Luzzatto, 1995) · Distorted body image ("skin and bones")	· Desire to be held (Rehavia-Hanauer, 2003) · Mental double trap (Luzzatto, 1995)
Defenses:	· Isolation · Splitting · Denial	· Isolation of affect · Denial	· Isolation · Denial
Developmental Level:	Combination pre-schematic and schematic	Combination pre-schematic and schematic	Combination pre-schematic and schematic
Color use:	· Wide range · Partially reality based	· Based on emotion	· Wide range · Partially reality based
Media choice:	Colored pencil	Colored pencil, marker, chalk pastel	Colored pencil, marker
Organic Features:	· Tilts · Overshoots · Undershoots	· Tilts · Overshoots · Undershoots	· Tilts

Transference

The following section analyzes the possible transference observed through Anthony's verbalizations, interactions and drawings that occurred during the art therapy sessions.

The first session began with Anthony describing a little about himself as he drew. Amongst other things, he stated that he would like to "contribute to society". It is possible that by volunteering to participate in this study was a way to fulfill this wish.

As discussed previously, the symbolism of two people standing in a valley (refer to Figure 5) may symbolize two of the six conflicts described by Rehavia-Hanauer (2003) as "the desire and need to be looked after and held and the verbal inability to directly express this need" (p. 142), and the desire to be both dependent and independent in relationships with others. The valley may be viewed as a holding environment, the mountains as mother or nurturance, yet at the same time the figures stand on separate mountains and divert their eyes away from each other. In terms of transference, one may wonder whether the symbolism expresses a wish to be held and to remain separate in his relationship to the therapist.

The topic of gender was initiated by Anthony in sessions one and two, when Anthony asked to work with a male therapist and seemed to depict the hospital environment as both feminine and oppressive. As discussed previously, given the possible connection between his mother and femininity, it is likely that Anthony was experiencing a transferential relationship while in treatment with the author. For example, not only did Anthony ask not to be treated by a female therapist for his individual sessions, but he also stated that he was having difficulty relating to the young women on the unit. Shaverien discusses the importance of the transferential relationship in the recovery of Carlos, where the therapist seemed to symbolically represent his

mother. Through the transference Shaverien hypothesized that Carlos was able to confront his issues with his family, specifically his mother, as well as femininity. Perhaps it is important to the recovery process for a male eating disorder patient to be given the opportunity to recreate the mother-child relationship through contact with a female therapist. More research is needed to corroborate this hypothesis.

Countertransference

The case study recorded by Shaverien (1995) highlighted the importance of recognizing countertransferential issues that surface working with patients of the opposite sex (see Art Therapy and Men with Eating Disorders). This subsection will discuss my countertransference towards Anthony that developed over the three art therapy sessions.

In the first art therapy session, one may recall that Anthony asked if he could receive individual treatment by a male psychologist who was a part of the treatment team, rather than working with myself and another young female intern. I responded by explaining that the treatment team had assigned his therapists and that he could therefore ask the treatment team whether a change would be possible. This was not only a truthful statement regarding the procedures within this inpatient setting, but also an invitation for Anthony to have a say in his own treatment, since issues of control are often present with anorexics. I went on to acknowledge both the gender and age difference between the patient and myself. (Although Anthony only mentioned the difference in gender between us, I felt it necessary to recognize the fact that he was being treated by a therapist approximately half his age.) It is possible that I brought this up as a result of my own issues with older men; however, I believe that it is important to the formation of the therapeutic alliance to acknowledge diversity between patient and therapist, which includes differences in culture, gender and age.

The topic of gender continued into the second session, where Anthony created Figure 6 and discussed his difficulty relating to the female patients and staff to the point that he was considering terminating treatment. At this juncture, I began empathizing with Anthony as I did not have the experience of being the only male patient on a primarily female unit. Furthermore, I had already suspected that sexual identity issues may be at play before the third session, at which time Anthony discussed this conflict overtly. I wondered how questioning one's sexuality may affect one's comfort level in an environment consisting mainly of females. The purpose of reflecting upon this thought is not to lead the reader to the conclusion that a male eating disorder patient should be treated by a male therapist. Rather, more research is needed exploring the merits and limitations of a male eating disorder patient receiving treatment from a female therapist.

The second session began with Anthony stating that he wanted to terminate treatment. In order to gain more insight as to why he was considering this, I responded by suggesting an art directive. I asked if he could *express what it is like to be in treatment*. Anthony created Figure 6 and stated that he "should be able to do this on my own", referring to recovery. I chose to address Anthony's resistance by offering my clinical observation that oftentimes eating disorder patients leave treatment before they are ready, although they may feel like they are ready. I also pointed out that eating disorders may be deceptive in that way, and that although he may not agree, extra support can be helpful in combating the illness. The reasons for these statements were twofold. First, I had made similar statements to other patients (both male and female) that I had worked with prior to Anthony. As explained throughout Chapter 2, eating disorder patients are usually resistant to treatment, especially anorexics. I often try to point this out to patients who are considering leaving treatment. Sometimes a more confrontational approach seems to be merited, especially

when one considers the serious health consequences of their behaviors. Second, Anthony was the only male who qualified and consented to this case study since I had received approval to conduct this research. My desire to complete this study may have unknowingly contributed to a willingness to discuss my clinical observations.

When Anthony mentioned the "incident" and considered whether he should divulge what had happened, I found myself in a dilemma. I was curious about what this issue was and I wanted present a compelling case study to the readers of this thesis. However, although I realized that treatment was the primary concern, I also wondered if Anthony might come to regret discussing the "incident", since it would be included in this case study and our therapeutic relationship would soon be severed. I therefore tried to provide Anthony with as much information possible in order for him to be able to make an informed decision. I reminded him that the entire Eating Disorder Unit staff would have access to this information, as would the readers of this case study. He did not reveal the details of the "incident" during this session, and I felt relieved because I did not want to end our therapeutic relationship without being able to offer closure to what may have been revealed.

Limitations

As stated in Chapter 1, the small number of subjects recruited delimits this case study and therefore the results are not generalizable. It should be noted that in the eight months that the author interned at Friends Hospital, eight males, five of whom were over the age of 18 entered inpatient hospitalization for an eating disorder. Of the five potential candidates, only one male patient qualified and consented for the study after the author had received approval to conduct research by both Drexel University and Friends Hospital. The study allowed for a maximum of three male subjects between the ages of 18 and 60, who were undergoing inpatient treatment

at Friend's Hospital to be recruited and participate in three individual art therapy sessions each during the course of the study. Due to these boundaries, the results of this case study cannot be generalized to males under the age of 18, males who are over the age of 60, or males receiving art therapy for more than a one-week period.

Although Friends Hospital accepts men in their eating disorders clinic, and the number of men seeking treatment has been rising since the 1980s (Braun et al. 1999), only one qualifying anorexic male was admitted for inpatient treatment during the time period of the study. Future studies are needed to include additional data in order to support the findings of this case study.

Another limitation surfaced during the first art therapy session, which took place in a room that was commonly used for family therapy. The arrangement of the room was different than the subsequent two sessions and Anthony was asked to use a firm piece of cardboard as a drawing board because the only table in the room was a coffee table, which was low to the ground. This affected the line quality of the first drawing, as pointed out above, where the lines of the mountains were uneven due to the texture of the cardboard.

Implications for Future Research

Although the methodology of this case study originally included the possibility of recruiting three eating disorder males, only one anorexic male completed the study. Furthermore, this case study took place over a short duration of time, allowing for the completion of three art therapy sessions. Anthony's case also highlights the question of transference between a female therapist and a male patient. It is recommended that future research include:

- More subjects.

- Other subtypes of the eating disorder diagnosis, such as bulimia, eating disorder NOS and binge eating disorder.
- more art therapy sessions over a longer time period.
- An examination of changes in developmental level, color use, media choice and line quality in the artwork of anorexic males during the re-feeding process.
- An investigation whether the transferential relationship between a female therapist and a male anorexic patient is useful, a hindrance or inconsequential to the recovery of the patient.

CHAPTER 6: SUMMARY AND CONCLUSIONS

An exploratory qualitative case study design was used in order to describe the art therapy process, explore the symbolism contained in the artwork, and gather additional information regarding the nature of eating disorders in men. This study addressed the research questions: What is the process of art therapy treatment with the eating disordered male, as seen through the subject? What is the nature of the artwork produced by the eating disordered males, as seen through the subject? Although the methodology allowed for three male subjects, only one anorexic male qualified to participate in the study. The patient was a 51-year-old anorexic male who was hospitalized over one week, allowing for the completion of three individual art therapy sessions, resulting in three drawings that were analyzed based on literature describing the characteristics and artwork of eating disorder patients. Struggles that are commonly found within the artwork of female anorexic patients, such as denial of the body and difficulties with family dynamics, seemed to emerge in the artwork and verbalizations of the participant. The findings also suggest that the patient struggles with his sexual identity, which is a common feature of men with eating disorders. Future studies will be needed to corroborate these results, as well as to extend the research period to over a one week period in order to examine possible artistic changes throughout the re-feeding process. The findings also suggest that further research is needed in regards to the transferential relationship between a female therapist and a male anorexic patient. Lastly, as this study only included one male diagnosed with anorexia, more research is needed describing the art therapy process and symbolism of men diagnosed with bulimia, eating disorder NOS or binge eating disorder.

Reference

American Art Therapy Association. (2007). http://www.arttherapy.org. Accessed on October 28, 2007.

Aminoff, M. J. (1998). Do nonconvulsive seizures damage the brain? – no. *Archives of neurology, 55.*

Anderson, E. A., & Holamn, J. E. (1997). Males with eating disorders: Challenges for treatment and research. *Psychopharmacology Bulletin, 33*, 291-299.

Austin, S. B., Ziyadeh, N., Kahn, J. A., Camargo, C. A., Colditz, G. A., & Field, A. E. (2004). Sexual orientation, weight concerns, and eating disordered behaviors in adolsecent girls and boys. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(9).

Ball, J., & Ball, R. (1995). *Eating disorders a survival guide for family and friends.* Doubleday.

Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: a systematic review of the literature. *International Journal of Eating Disorders, 40*(4), 293-309.

Boskind-Lodahl, M. (1979). Cinderalla's stepsisters: A feminist perspective on anorexia nervosa and bulimia. *Signs, 2*, 342-356.

Bramon-Bosch, E., Troop, N. A., & Treasure, J. L. (2000). Eating disorders in males: A comparison with female patients. *European Eating Disorders Review, 8*(4), 321-328.

Braun, D. L., Sunday, S. R., Huang, A., & Halmi, K. A. (1999). More males seek treatment for eating disorders. *International Journal of Eating Disorders, 25*, 415-424.

Brenner, C. (1974). *An elementary textbook of psychoanalysis (rev. ed.).* Garden City, NY: Anchor Books.

Brownley, K. A., Berkman, N. D., Sedway, J. A., Lohr, K. N., & Bulik, C. M. (2007). Binge eating disorder treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders, 40*(4), 337-348.

Bruch, H. (1974). *Eating disorders: Obesity, anorexia nervosa, and the person within*. Basic Books.

Bulik, C. M., Berkman, N. D., Brownley, K. A., Sedway, J. A., & Lohr, K. N. (2007). Anorexia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*, *40*(4), 310-320.

Carlat, D. J., Camargo, C. A., & Herzog, D. B. (1997). Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*, *154*(8), 1127-1132.

Cash, T. F., Morrow, J. A., Hrabosky, J. I., & Perry, A. A. (2004). How has body image changed? a cross-sectional investigation of college women and men from 1983 to 2001. *Journal of Consulting and Clinical Psychology*, *72*(6), 1081-1089.

Caspi, A., McClay, J., Moffitt, T., Mill, J., & Craig, I. (2002). Role of genotype in the cycle of violence in maltreated children. *Science*, *297*, 852-854.

Caspi, A., Sugden, K., Moffitt, T., Taylor, A., Craig, I., & Harrington, H. (2003). Influence of lide stress on depression: Moderation by polymorphism in the 5-htt gene. *Science*, *301*, 386-389.

Cleveland, E. (1999). Addressing psychological complications of eating disorders in children and adolescents through art therapy. Philadelphia, PA: Jessica Kingsley Publishers.

Cohane, G. H., & Pope, H. G. (2001). Body image in boys: A review of the literature. *International Journal of Eating Disorders*, *29*, 373-379.

Cole-Detke, H., & Kobak, R. (1996). Attachment processes in eating disorder and depression. *Journal of Consulting and Clinical Psychology*, *64*, 282-290.

Cronin, S. M., & Werblowsky, J. H. (1979). Early signs of organcity in art work. *Art Psychotherapy*, *6*.

Crowl, M. A. (1980). Art therapy with patients suffering from anorexia nervosa. *The Arts in Psychotherapy*, *7*, 141-151.

Dally, P. (1969). *Anorexia nervosa*. Grune & Stratton.

Davis, C., & Scott-Robinson, L. (2000). A psychological comparison of females with anorexia nervosa and competitive male body builders: Body shape ideals in the extreme. *Eating Behaviors*, *1*, 33-46.

Diagnostic and statistical manual (3rd ed.). (1980). Washington, DC: American Psychiatric Association.

Diagnostic and statistical manual (4th ed.). (2000). Washington, DC: American Psychiatric Association.

Field, F., Camargo, C. A., & Taylor, C. B. (1999). Overweight, weight concerns, and bulimic behavior among boys and girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, *38*, 373-379.

Fleming, L. (1989). Experiential therapies for eating disorders. In H. A. Baker (Ed.), (chap. Art therapy and anorexia: Experiencing the authentic self). New York, NY: Guilford.

Frisch, M. J., Franko, D. L., & Herzog, D. B. (2006). Arts-based therapies in the treatment of eating disorders. *Eating Disorders*, *14*, 131-142.

Geist, R., Heinma, M., Katzman, D., & Stephens, D. (1999). A comparison of male and female adolescents referred to an eating disorder program. *Canadian Journal of Psychiatry*, *44*, 374-378.

Gillespie, J. (1996). Rejection of the body in women with eating disorders. *The Arts in Psychotherapy*, *23*(2).

Goldfield, G. S., Blouin, A. G., & Woodside, D. B. (2006). Body image, binge eating, and bulimia nervosa in male bodybuilders. *Canadian Journal of Psychiatry*, *51*(3), 160-168.

Groesz, Levine, & Murnen. (2002). The effects of experimental presentation of thin media images on body satisfaction: A meta-analytic review. *International Journal of Eating Disorders*, *21*, 1-16.

Haines, J., & Neumark-Sztainer, D. (2006). Prevention of obesity and eating doisorders: a consideration of shared risk factors. *Health Education Research Theory & Practice*, *21*(6), 770-782.

Hall, P., & Driscoll, R. (1993). Anorexia in the elderly- an annotation. *International Journal of Eating Disorders*, *14*(4), 497-499.

Halliwell, E., & Harvey, M. (2006). Examination of a sociocultural model of disordered eating among male and female adolescents. *British Journal of Health Psychology*, *11*, 235-248.

Hallsworth, L., Wade, T., & Tiggermann, M. (2005). Individual differences in male body-image: an examination of self-objectification in recreational body builders. *British Journal of Health Psychology*, *10*, 453-465.

Harris, M., & Cumella, E. J. (2006). Eating disorders across the life span. *Journal of Psychosocial Nursing & Mental Health Services*, *44*(4), 20-26.

Health, T. U. S. D. of, & Services, H. (n.d.). *Poverty Line.* http://aspe.hhs.gov/poverty/04poverty.shtml. Accessed on October 28, 2007.

Hillege, S., Beale, B., & McMaster, R. (2006). Impact of eating disorders on family

life: individual parents' stories. *Journal of Clinical Nursing*, *15*, 1016-1022.

Hinz, L. D., & Ragsdell, V. (1990). Using masks and video in group psychotheray with bulimics. *The Arts in Psychotherapy*, *17*, 259-261.

Jacobi, J. (1973). *The psychology of c. g. jung.* New Haven, CT: Yale University Press.

Jansen, A., Smeets, T., Martijn, C., & Nederkroon, C. (2006). I see what you see: the lack of a self-serving body-image bias in eating disorders. *British Journal of Clinical Psychology*, *45*, 123-135.

Johnson, K., & Parkinson, S. (1999). There's no point raging on your own: Using art therapy in groups for people with eating disorders. *Group Analysis*, *32*, 87-96.

Jones, D. C. (2004). Body image among adolescent girls and boys: a longitudinal study. *Developmental Psychology*, *40*(5), 823-835.

Jung, C. G., Adler, G., & Hull, R. F. C. (1977). *Symbols of transformation (collected works of c. g. jung)* (Vol. 5). Princeton, NJ: Princeton University Press.

Kellett, J., Timble, M., & Thorley, A. (1976). Anorexia nervosa after the menopause. *British Journal of Psychiatry*, *28*, 323-328.

Kiang, L., & Harter, S. (2006). Sociocultural values of appearance and attachment processes: an integrated model of eating disorder symptomatology. *Eating Behaviors*, *7*, 134-151.

Kimmel, S. B., & Mahalik, J. R. (2005). Body image concerns of gay men: The roles of minority stress and confromity to masculine norms. *Journal of Consulting and Clinical Psychology*, *73*(6), 1185-1190.

Lauder, M. A. (1978). Anorexia nervosa later in life. *British Journal of Medicine Psychology*, *51*, 375-377.

Lavender, A., Shubert, I., & Silva, P. de. (2006). Obsessive-compulsive beliefs and magical ideation in eating disorders. *British Journal of Clinical Psychology*, *45*, 331-342.

Leit, R. A., Jr., H. G. P., & Gray, J. J. (2001). Cultural expectation of muscularity in men: The evolution of playgirl centerfolds. *International Journal of Eating Disorders*, *29*, 90-93.

Levens, M. (1987, Summer). Art therapy with eating disordered patients. *Inscape: The Journal of the British Association of Art Therapists.*

Levens, M. (1990). Borderline aspects in eating disorders: Art therapy's contribution. *Group Analysis*, *23*, 277-284.

Levick, M. (1983). *They could not talk and so they drew.* Springfield, IL: Charles C Thomas.

Lowenfeld, V., & Brittain, W. L. (1982). *Creative and mental growth* (8th ed.). New York, NY: Macmillan Publishing.

Lubbers, D. (1991). Adult art psychotherapy: issues and applications. In H. B. Landgarden & D. Lubbers (Eds.), (chap. Treatment of women with eating disorders). New York, NY: Brunner/Mazel.

Makin, S. R. (2000). *More than just a meal: the art of eating disorders.* Philadelphia, PA: Jessica Kingsley Publishers.

Mangweth, B., Hausmann, A., Danzl, C., Walsch, T., Rupp, C. I., Biebl, W., et al. (2005). Childhood body-focused behaviors and social behaviors as risk factors of eating disorders. *Psychotherapy and Psychosomatics*, *74*, 247-253.

Matto, H. C. (1997). An integrative approach to the treatment of women with eating disorders. *The Arts in Psychotherapy*, *24*(4), 347-354.

Mauler, B. I., Hamm, A. O., & Weike, A. I. (2006). Affect regulation and food intake in bulimia nervosa: emotional responding to food cues after deprivation and subsequent eating. *Journal of Abnormal Psychology*, *115*(3), 567-579.

Mitchell, D. (1980). Anorexia nervosa. *The Arts in Psychotherapy*, *7*, 53-60.

Money Income of Households – Distribution by Income Level and Selected Characteristics: 2004. (n.d.). http://www.census.gov/ Accessed on October 28, 2007.

Morgan, C. D., & Marsh, C. (2006). Bulimia nervosa in an elderly male: a case report. *International Journal of Eating Disorders*, *39*(2), 170-171.

Muise, A. M., Stein, D. G., & Arbess, G. (2003). Eating disorders in adolescent boys: A review of the adolescent and young adult literature. *Journal of Adolescent Health*, *33*, 427-435.

Naitove, C. E. (1986). "life is but a walking shadow" treating anorexia nervosa and bulimila. *The Arts in Psychotherapy*, *13*, 107-119.

Naumburg, M. (1987). *Dynamically oriented art therapy: Its principles and practice.* Chicago, IL: Magnolia Street Publishing.

Newman, B. M., & Newman, P. R. (2003). *Development through life: a psychosocial approach.* Belmont, CA: Wadsworth/Thompson Learning.

O'Dea, J., & Abraham, S. (2002). Eating and exercise disorders in young college men. *Journal of American College Health*, *50*, 273-278.

Paxton, S. J., Eisenberg, M. E., & Neumark-Sztainer, D. (2006). Prospective predic-

tors of body dissatisfaction in adolescent girls and boys: A five-year longitudinal study. *Developmental Psychology*, *42*(5), 888-899.

Pine, K. J. (2001). Children's perceptions of body shape: A thinness bias in pre-adolescent girls and associations with femininity. *Clinical Child Psychology and Psychiatry*, *6*(4), 519-536.

Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review Psychology*, *53*, 187-213.

Rayworth, B. B., Wise, L. A., & Harlow, B. L. (2004). Childhood abuse and risk of eating disorders in women. *Epidemiology*, *15*(3), 271-278.

Rehavia-Hannauer, D. (2003). Identifying conficts of anorexia nervosa as manifested in the art therapy process. *The Arts in Psychotherapy*, *30*, 137-149.

Russell, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders*, *31*, 300-306.

Russell, G. F. M. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. *Psychological Medicine*, *9*, 429-448.

Rust, M. J. (2000). Arts therapies and clients with eating disorders: Fragile board. In D. Dokter (Ed.), (chap. Bringing the 'man'into the room: art therapy group-work with women with complusive eating problems). Philadelphia, PA: Jessica Kingsley Publishers.

Sansone, R. A., & Sawyer, R. (2005). Weight loss pressure on a 5 year old wrestler. *British Journal of Sports Medicine*, *39*(E2).

Schaverien, J. (1995a). Arts therapies and clients with eating disorders: Fragile board. In D. Dokter (Ed.), (chap. The picture as transactional object in the treatment of anorexia). Philadelphia, PA: Jessica Kingsley Publishers.

Schaverien, J. (1995b). *Desire and the female therapist: Engendered gazes in psychotherapy and art therapy.* New York, NY: Routledge.

Schmidt, U. H., Troop, N. A., & Treasure, J. L. (1999). Events and the onset of eating disorders: correcting an "age old" myth. *International Journal of Eating Disorders*, *25*, 83-88.

Shapiro, J. R., Berkman, N. D., Brownley, K. A., Sedway, J. A., Lohr, K. N., & Bulik, C. M. (2007). Bulimia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*, *40*(4), 321-336.

Smolak, L., & Murnen, S. K. (2002). A meta-analytic examination of the relationship between child sexual abuse and eating disorders. *International Journal of Eating Disorders*, *21*, 136-150.

Stein, R. I., Saelens, B. E., Dounchis, J. Z., Lewezyk, C. M., Swenson, A. K., & Wilfley, D. E. (2001). Treatment of eating disorders in women. *The Counceling Psychologist*, *29*(5), 37.

Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin*, *128*, 825-848.

Stice, E., Presnell, K., & Spangler, D. (2002). Risk factors for binge eating onset in adolescent girls: A 2 year prospective investigation. *Health Psychology*, *21*, 131-138.

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *American Psychologist*, *62*(3), 181-198.

Striegel-Moore, R. H., Garvin, V., Dohm, F. A., & Rosenheck, R. A. (1999). Psychiatric comorbidity of eating disorders in men: A national study of hospitalized veterans. *International Journal of Eating Disorders*, *25*, 399-404.

Sullivan, P. F. (1995). Mortality in anorexia nervosa. *American Journal of Psychiatry*, *152*, 1073-1074.

Ticen, S. (1990). Feed me...cleanse me...sexual trauma projected in the art of bulimics. *Art Therapy: Journal of the American Art Therapy Association*, *7*(1).

Tiggemann, M., Martins, Y., & Kirkbride, A. (2007). Oh to be lean and muscular: Body image ideals in gay and heterosexual men. *Psychology of Men and Masculinity*, *8*(1).

Wadeson, H. (1980). *Art psychotherapy.* United States of America: John Wiley & Sons Inc.

Waller, D. (1981). *Art therapy in the treatment of eating disorders.* (Goldshmiths' College, University of London, UK)

Warriner, E. (1995). Arts therapies and clients with eating disorders: Fragile board. In D. Dokter (Ed.), (chap. Anger is red). Philadelphia, PA: Jessica Kingsley Publishers.

Weltzin, T. E. (2007). Eating disorders in men: What you need to know. *Clinician's Research Digest*, *25*(7).

Williamson, I., & Hartley, P. (1998). British reasearch into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review*, *6*(3).

Woodside, D. B., Garfinkel, P. E., Lin, E., Goering, P., Kaplan, A. S., Goldbloom, D. S., et al. (2001). Comparison of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community.

American Journal of Psychiatry, *158*(4), 570-574.

Young, G. B., & Jordan, K. G. (1998). Do nonconvulsive seizures damage the brain? – yes. *Archives of neurology*, *55*.

Appendix A: Consent Form

Participant's Initials _____

Drexel University
Consent to Take Part
In a Research Study

1. **Participant Name**:_____
2. **Title of Research**: Art Therapy with an Eating Disordered Male Population: a Case Study.
3. **Investigator's Name**: Betty Hartzell Ph.D., ATR-BC, LPC
   Co-Investigator: Elizabeth Beck
4. **Research Entity**: Drexel University and Friends Hospital
5. **Consenting for the Research Study**: This is a long and an important document. If you sign it, you will be authorizing Drexel University and its researchers to perform research studies on you. You should take your time and carefully read it. You can also take a copy of this consent form to discuss it with your family member, physician, attorney or any one else you would like before you sign it. Do not sign it unless you are comfortable in participating in this study.
6. **Your right to privacy and confidentiality**: Very specific information on your right to privacy and the confidentiality of the use and disclosure of your personal health information can be found at the end of this consent form. We need your authorization to use and disclose the health information that we may collect about you during this research study. To be in this research study you must read and sign the authorization at the end of this consent form.
7. **Purpose of research**: You are being asked to participate in a research study. The purpose of this study is to explore the art therapy process with the subjects as well as describe the symbolism used in the artwork. Furthermore, the purpose is to compare the artwork of the three male eating disordered subjects to females with eating disorders who have been previously discussed within art therapy literature. This study is in partial fulfillment of a master's degree in the Creative Arts in Therapy Program at Drexel University's Hahnemann Center City Campus.

   A maximum of three participants will take part in this study. In order to qualify for this study you must be male, between the ages of 18 to 60, have received a diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder NOS, and is to be hospitalized for at least one week with the completion of three individual sessions with the researcher. In the event that you are under the age of 18, are hospitalized for under one week and/or you have received a diagnosis of substance abuse, substance dependence, schizophrenia or psychosis, you will not qualify for this

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study. Due to the voluntary nature of this research, you may withdraw from this study at any time.

8. **Procedures and duration**: You understand that the following things will be done:
    - The art therapy student completing this research will meet with you for three individual art therapy sessions, 45 minutes each, over a one-week period.
    - The first session will consist of an art therapy assessment, the BATES, whose sole instructions are "draw two people doing something in a place which will be explained to you in detail. Apart from this first assessment, the subsequent sessions will be conducted according to your needs and goals, which will be determined from the initial art therapy assessment and the first art therapy session.
    - After each session, you will be asked if you would like to keep the originals of your artwork. Whether you choose to keep your artwork or not, the researcher will take a digital photograph of the piece(s) created. The digital photograph will be transferred to the researcher's computer and burned to a CD. The photograph will be deleted from the researcher's camera, computer and CD after the completion of the research study.
    - In addition to each individual session, data will be gathered from your chart, art therapy notes, group notes, information given during treatment team meetings.

9. **Risks and discomforts/constraints**: The possible risks and discomforts include the anxiety that is involved when raising issues during the therapeutic process as well as anxiety associated with the art making during each art therapy session.

10. **Unforseen Risks**: The office number of the Primary Investigator, Betty Hartzell, Ph.D., ATR-BC, LPC, (215) 762-3767 is available for those experiencing an unforeseen reaction to this study. Upon request, short breaks during the art therapy sessions may be included in order to reduce your anxiety. In an unforeseen reaction occurs, you may also be referred to the art therapist or other therapists on staff. Furthermore, upon the occurrence of an unforeseen event, the Office of Research Compliance (215) 762-3453, will be notified.

11. **Benefits**: There may be no direct benefits to you from participating in this study.

12. **Alternative procedures/treatments**: The alternative is not to participate in this study.

Participant's Initials _____

13. **Reasons for removal from this study**: You may be required to stop the study before the end for any of the following reasons:
- Change in medical condition;
- If all or part of the study is discontinued for any reason by the sponsor, investigator, university authorities, or government agencies; or
- Other reasons, including new information available to the investigator or harmful unforeseen reactions experienced by the subject or other subjects in this study.

14. **Voluntary Participation**
Patients: You understand that being in this study is voluntary. Your health care will not be affected in any way if you decline to be in or later withdraw from the study.

15. **Responsibility for cost**: All costs relating to this study will be included as a part of the normal course of treatment at Friends Hospital.

16. **In case of injury**: If you believe that you have been injured in any way, you should contact Betty Hartzell, Assistant Director of Graduate Art Therapy Education at Drexel University, at telephone number (215) 762-3767. However, neither the investigator nor Drexel University will make payment for injury, illness, or other loss resulting from your being in this research study. If you are injured by this research activity, medical care including hospitalization is available, but may result in costs to you or your insurance company because the University does not agree to pay for such costs. If you are injured or have an adverse reaction, you should also contact the Office of Research Compliance at 215-762-3453.

17. **Confidentiality**: This section gives more specific information about the privacy and confidentiality of your health information. It explains what health information about you will be collected during this research study and who may use, give out and receive your health information. It also describes your right to inspect your medical records and how you can revoke this authorization after you sign it.

By signing this form, you agree that your health information may be used and disclosed during this research study. Your health information may be disclosed or transmitted electronically. We will only collect information that is needed for the research study. Your health information will only be used and given out as explained in this consent form or as permitted by law. In any publication or presentation of research results, your identity will be kept confidential.

A. Individually Identifiable Heath Information that will be collected.
The following personal health information about you will be collected and used during the research study and may be given out to others:

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- Personal and family psychiatric history. This information will be collected due to the nature of a case study, which examines each participant's unique history, status and course of treatment. Collecting this information allows your unique goals of therapy to be established and will aid in the direction of the therapeutic process.

B. Who will see and use your health information within Drexel University.
The research study investigator and other authorized individuals involved in the research study at Drexel University will see your health information and may give out your health information during the research study. These include the research investigator and the research staff, the institutional review board and their staff, legal counsel, research office and compliance staff, officers of the organization and other people who need to see the information in order to conduct the research study or make sure it is being done properly.

C. Who else may see and use your health information.
Other persons and organizations outside of Drexel University may see and use your health information during this research study. These include: Doctors and staff at the hospital where this research study will take place.

D. Why your health information will be used and given out.
Your health information will be used and given out to carry out the research study and to evaluate the results of the study.

E. If you do not want to give authorization to use your health information.
You do not have to give your authorization to use or give out your health information. However, if you do not give authorization, you cannot participate in this research study.

F. How to cancel your authorization.
At any time you may cancel your authorization to allow your health information to be used or given out by sending a written notice to the Office of Research Compliance, 245 N. 15th Street, Mail Stop 444, Philadelphia, Pennsylvania, 19102. If you leave this research study, no new health information about you will be gathered after you leave. However, information gathered before that date may be used or given out if it is needed for the research study or any follow-up.

G. When your authorization ends.
Your authorization to use and give out your health information will end when the research study is finished. After the research study is finished all photographs of artwork created will be deleted from the CDs used to store

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the visual images. Furthermore, after the study is finished, your health information will be maintained in a research database. Drexel University shall not re-use or re-disclose the health information in this database for other purposes unless you give written authorization to do so. However, the Drexel University Institutional Review Board may permit other researchers to see and use your health information under adequate safety guards.

H. Your right to inspect your medical and research records.
You have the right to look at your medical records at any time during this research study. However, the investigator does not have to release research information to you if it is not part of your medical record.

18. **Other considerations**: If you wish further information regarding your rights as a research subject or if you have problems with a research-related injury, for medical problems please contact the Institution's Office of Research Compliance by telephoning 215-762-3453.

Participant's Initials _____

19. CONSENT:

- I have been informed of the reasons for this study.
- I have had the study explained to me.
- I have had all of my questions answered.
- I have carefully read this consent form, have initialed each page, and have received a signed copy.
- I authorize the use and disclosure of my personal health information as explained in this consent form.
- I give consent voluntarily.

_____ _____

Subject or Legally Authorized Representative Date

_____ _____

Investigator or Individual Obtaining this Consent Date

List of Individuals Authorized to Obtain Consent

Name	Title	Day Phone #	24 Hr Phone #
Betty Hartzell,	Primary Investigator Ph.D., ATR-BC, LPC	(215) 762-3767	(215) 762-3767
Elizabeth Beck,	Co-investigator BA	(215) 307-6406	(215) 307-6406

Appendix B: Training Form

A graduate art therapy student is seeking male volunteers to participate in a research study examining the art therapy process with males who have been diagnosed with an eating disorder. The title of this research is: Art Therapy with an Eating Disordered Male Population: A Case Study.
Volunteers must be:

- Male
- 18 to 60 years of age
- Hospitalized for at least a one-week period
- Have received a diagnosis of Anorexia Nervosa, Bulimia Nervosa or Eating Disorder NOS

Volunteers do not qualify for this study if:

- They have received a diagnosis of substance abuse or dependence
- They have received a diagnosis of schizophrenia or psychosis

The study will consist of:

- One approximately 20-minute session reviewing the consent form
- Three individual art therapy sessions, lasting 45 minutes each

All artwork produced will be the participants to keep. There will be no monetary compensation. Please give a flyer to any qualifying participants informing them of the research criteria and to contact Elizabeth Beck, the student art therapist on the Friends Hospital eating disorder unit.
This research is conducted by a researcher who is a member of Drexel University, research advisor Betty Hartzell, Ph.D., ATR-BC, LPC.

Appendix C: Letter of Permission to Conduct Research

FRIENDS HOSPITAL

November 3, 2006

Drexel University
Philadelphia, Pa.

Re: Research Project

To Whom It May Concern:

Please be advised that Elizabeth Beck has received permission to conduct a research project for her Masters Thesis. Research will take place on the Eating Disorders Unit at Friends Hospital.

Sincerely,

Carol Inskeep, APRN, BC
Chief Nursing Officer
Vice President for Clinical Services

CI:ps

4641 Roosevelt Boulevard Philadelphia, PA 19124-2399 (215) 831-4600 Fax (215) 289-92