Speaking the Unspeakable: Artistic Expression in Eating Disorder Research and Schema Therapy

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Highlights

- Drawings in eating disorder research can give women a voice
- Social discourses define the link between child sexual abuse and eating disorders
- Drawings in Schema Therapy can access emotions inaccessible through words
Abstract

This research study shows how drawing can be used in eating disorder research to uncover multiple meanings to develop, support, and supplement research findings. The processes of the research give women a voice to describe and process their experiences of having an eating disorder. The first section reports the response of a research participant in a study that used spoken, written and visual data to examine women’s experiences of eating disorders and child sexual abuse. In the second section, a case study demonstrates how drawings created by clients in Schema Therapy for eating disorders can provide a pathway to access emotional states, which may otherwise be inaccessible through verbal dialogue. Using drawing can enable research participants to share insights and experiences in non-verbal ways. Drawing as part of schema therapy can provide the opportunity for the practitioner and the client to feel and experience complex emotional states related to current and past experience.

Key words: Eating disorders; abuse; drawing; schema therapy

From the perspective of medicine, eating disorders are viewed as mental disorders, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013). Eating disorder explanations draw on notions of hysteria, where a woman is seen to have character flaws, such as being a perfectionist who desires control (Bordo, 2009; Frost, 2001; Malson, 1998; Rich, 2006; Saukko, 2009). In a similar way, child sexual abuse is understood, in medical terms, as resulting in the development of mental illness (O’Dell, 2003; Reavey & Gough, 2000; Stoltenborgh, 2011). It is easier to think about the enduring misery created by child sexual abuse in terms of illness. However, distress is
privatised when women’s abuse experiences are pathologised. In this paper, by making the pathologising politics of both child sexual abuse and eating disorders visible, we are not attempting to invalidate women’s subjectively experienced pain, anger, fear, loneliness, and sadness. Women’s distress is indisputably meaningful. Instead, we want to question the way in which the prevailing conceptualisations of eating disorders and child sexual abuse as individual pathologies have shaped accepted truths about these two phenomena.

Advocates of the biomedical view, as Brumberg (1988: 25) notes, “assume that aberrations of human behaviour can be explained by deviance or disorder in biological processes”. Diagnosis is, therefore, central within the practice of medicine because it translates individual experience into internalised disorder (Lafrance & McKenzie-Mohr, 2013; Warner & Wilkins, 2003). A biomedical construction of distress, however, as Lafrance and McKenzie-Mohr (2013: 119) assert, may offer “the lure, or promise, of validating persons’ pain and legitimizing their identities”. Yet through an eating disorder diagnosis, psychiatry’s hegemonic medicalised framing of women’s distress forces women into predetermined narratives where their voices or struggles are given a causal label and they are positioned as victims. In this way, how individuals view themselves and their actions is shaped by psychiatry. This has a powerful effect on regulating what counts in society. Such a dominance is maintained “not only by powerful corporate interests such as the pharmaceutical industry, but also through the everyday talk of people as they attempt to make meaning of themselves and their experiences” (Lafrance & McKenzie-Mohr, 2013: 199). Thus, the effect of psychiatric discourse infiltrates our language and consciousness in ways that are then taken for granted.

**Methodology**
The doctoral research on which this article reports was specifically concerned with the nature of the relationship between women’s experiences of child sexual abuse and eating disorders. The study was not concerned with causation. The theoretical and methodological underpinnings of this study were situated within a qualitative research paradigm because it was concerned with the constitutive role played by language in structuring the way in which women understood eating disorders, the nature of their experiences, and the causes of their distress. We used a contemporary feminist framework that was sensitive to poststructural concepts, and the Russian philosopher Mikhail Bakhtin’s (1895-1975) sociological linguistics to analyse women’s understandings of two highly-gendered issues – child sexual abuse and eating disorders – to contribute to a better understanding of the relationship between them. In our use of the term *poststructural concepts*, we refer to the challenging ways poststructuralist, postmodernist and multiculturalist modes of analysis have informed feminist theory and practice (see Genz & Brabon, 2010). We considered this theoretical and methodological framework important for two reasons: First, it was capable of enabling the women to express how they resisted trauma as it allowed us to explore how multiple discourses worked within the women’s narratives. Through the lens of Bakhtin’s dialogics, the women’s discourse could be read as multivocal. By the term ‘multivocal’ we meant that any given word is multivoiced in that it is saturated with ideology and meaning from previous usage (Riessman, 2008).

Secondly, this theoretical and methodological framework allowed us to work out how meaning of the narratives was constructed in a dialogic relationship between the researcher and the participant. Very specifically, the use of dialogic theory in a feminist context allowed research with women with eating disorders to be conducted in a more mutually and critically reflective manner (Saukko, 2000). As dialogism
emphasises women’s engagement in their own struggles of understanding, dialogic processes did not passively record where the women were in their lives. Meaning was not transmitted; it was built in the process of interaction in a kind of ideological bridge. As speech, and its production, is tied to the politics and practices bound up with daily life (Probyn, 1993), through a feminist dialogics, hegemonic voices, contradictions and silences in women’s narratives could be exposed and alternative meanings explored (Bauer & McKinstry, 1991).

*Authoritative discourse* and *internally persuasive discourse* are two theoretical constructs described in Bakhtin’s ‘Discourse in the Novel’ that informed our analysis and promoted a feminist agenda (Bakhtin, 1981). In ‘Discourse in the Novel’ Bakhtin suggests the novel generically undermines the absolutism of any one language, for example, scientific, moral, psychological, or religious discourse (Bakhtin, 1981). We used Bakhtin’s theoretical constructs to expose seemingly objective truths in the women’s narratives that overshadowed alternative discourses competing for expression. An *authoritative discourse* has such binding authority that it seems untouchable, inspires only adoration and respect, and maintains the status quo. In contrast, an *internally persuasive discourse* is denied all privilege, as it is “frequently not even acknowledged in society” (Bakhtin, 1981: 342). By looking for authoritative discourses in the women’s narratives, we could find internally persuasive discourses and investigate these with the women.

**Research Methods**

 Following a dialogical method, which considered verbal responses to be “themselves built on responses to historic utterances made by ourselves and others” (Francis, 2010: 4), the first author conducted up to five individual, semi-structured face-to-face interviews, averaging 90 minutes each in duration, with seven women
aged over 18 years who had an eating disorder and who had been sexually abused as children. The interviews were conducted over a twelve-month period to allow time to transcribe verbatim and analyse each interview before conducting subsequent interviews. After each interview with each woman, and before conducting further interviews with her, a copy of her interview transcript was offered to the woman. When undertaking the multiple interviews with each participant, the research process became a dialogue between the researcher and participant.

While we considered interviews to be an appropriate research method, the women who participated in this study found child sexual abuse difficult to talk about. They offered their own poetry, journals and drawings to be included in this research as an alternative way of communicating their experiences. Visual materials generate rich description in relation to specific or concrete experiences by allowing participants to tap into or access remembered sensuous, emotional, spatial and relational details (Del Busso, 2011; Liamputtong & Rumbold, 2008). Their artwork was used as evidence to develop, support and supplement research findings (Rose, 2008). Through this process, the women were afforded the opportunity to explore and interpret their own visual symbols (Eisenbach, Snir & Regev, 2015). We demonstrate how drawing is useful in both eating disorder research and psychotherapy through accessing experiences that are experienced as a ‘felt sense’ in the body that is beyond words.

First, we present a case study from the first author’s doctoral research as an example (see Hodge, 2014). In appropriating a Bakhtinian discourse analysis to the drawings in this study, particular attention was paid to the images, and to certain aspects of the social context of their production and effect. This was important because, a discourse analysis of images involved reading for what was not seen or said (Rose, 2008). This suggests that it is the absence in images that can be “as
productive as explicit naming: *invisibility* can have just as powerful effects as visibility” (Rose, 2008: 165 [original emphasis]).

Secondly, an exploration of how drawings are used in psychotherapy to promote healing is described. Schema Therapy is the specific psychotherapy model referred to within the second case study, an integrative transdiagnostic approach that was developed to specifically address complex and clinical issues (Young, Klosko & Weishaar, 2003). Schema ‘modes’ are facets of personality and coping mechanisms that are manifested in the here-and-now. Working with schema modes as they arise in therapy provided a flexible, non-pathologising approach that facilitated experiential processing of emotions and cognitions associated with childhood experiences including trauma, whilst linking these with current relationships and coping behaviours. Ultimately, Schema Therapy aims to help clients to recognise which of their emotional needs have not been met in the past, and to learn healthy ways of getting these met in their current relationships. The paper concludes with suggestions for practitioners who seek to use drawing to gain further insight into the ways in which people with eating disorders make sense of their world.

**Case Example: An Eating Disorder as a Form of Self-harm**

This section will present one case example from a study that took a dialogical approach to understanding women’s experiences of eating disorders and child sexual abuse (see Hodge, 2014). The current case example presents Analiese (a self-selected fictitious name), who was 24-years old at the time of the study. Diagnosed with anorexia, Analiese was used in the production of child pornography from the age of two until she ran away from home as a teenager. Analiese said that she had had ongoing contact with the Mental Health Services since she was twelve or thirteen years old and spent most of her high school years in and out of hospital for the eating
disorder, depression, self-harm and suicide attempts. Analiese had previously recorded her experience in the form of an art diary and this was included in the research process. The use of written and visual data, as part of the dialogical method, instigated reflections and allowed for expression of feelings that may not have previously been clear, even to Analiese. Thus, a space was created for an interactional process of discovery. We suggest that the power of Analiese’s drawings was the contextual and collaborative discussions that emerge as a result of them.

Analiese said that Image 1 represented her experiences of self-harm and suicide. We suggest the image portrays a skeletal body with a strong rope and a chair far enough away to indicate a desire for a hanging that will not fail. The featureless face in this image appears to metaphorically articulate unspeakable thoughts, emotions and the trauma that Analiese has endured. In fact, there is nothing life-like in this picture; there is no window and therefore no view to the outside world. This emphasises a sense of utter hopelessness and entrapment. Analiese’s body is so central in this picture that it takes up most of the space and the skeletal body itself provokes disgust via its prominent ribs and hipbone. As such, this implicates the viewer in a shared visceral reaction that is one of horror (Ferreday, 2003). Yet, by producing a physical sensation of revulsion, Analiese’s anorexic body appears to break down the distinction between the healthy subject and the abject Other (Ferraday, 2003).

If we consider the drawing at another analytical level, it is as if Analiese has metaphorically suffered a double death. The skeleton resembles a faceless corpse, which then hangs, and dies again. In this way, Analiese expresses herself as abject. Kristeva (1982: 4) describes “the utmost of abjection” as founded in the corpse. The corpse, according to Kristeva (1982: 109) is “a decaying body, lifeless, completely
turned into dejection, blurred between the inanimate and the inorganic...represents fundamental pollution”. Thus, it unsettles and confronts order and does not respect borders, positions, and rules. From this position, the image can be considered as abject because its untidiness violates not only biological but also normative boundaries. Without pride or dignity, it is self-abasing and disturbs the order of things in its representation of dying twice. Moreover, the catastrophe of the abject body in Image 1 cannot be contained by the suffering person because, when others witness abjection, they too become contaminated. Thus, Analiese’s hanging anorexic body is a sick and damaged body that causes experiences of, as Kristeva (1982: 2) points out, “brutish suffering” in the form of disorder, powerlessness, stigma and pain, resulting in an ominous seepage of matter of personal, moral, and social significance.
Image 1

When Analiese was asked to explain Image 1, through the dialogical process, she connected the child sexual abuse, self-harm and suicide with her eating disorder. She said she drew her body as “emaciated” because of all “the stuff that was going on” in her head around the abuse. Analiese said she wanted to die “either through anorexia” or by hanging herself:

Analiese: It sort of represents the connection between the self-harm and the anorexia stuff just by the mere fact that I was emaciated when I hung myself. And I think it was a representation of the cycle, that whilst I used my food to keep going and survive I knew that at the end of the road there wasn’t much else other than to end up dead, just because of the stuff that’s going on in my head. You end up wanting to die but you’re using it as a thing to keep going. It was that contradiction of starving yourself to death with something that’s keeping you going.

LH: So this image is a suicide attempt or do you consider it self-harm?

Analiese: I think it’s a bit of both. In one sense there’s the representation of where you end up wanting to be because of the mind trap. I don’t know how to explain it but the emotional shit of everything is so messed up because you’re so malnourished and you can’t think straight because everything you’re thinking about is food. And you think that once you reach that point that you’ve gone without food and you’ve made yourself skinny enough that everything will be better … you’re so emaciated that you end up physically so unhealthy that you’re likely to die anyway.
Bakhtin (1981: 345) contends that, when one’s “ideological discourse is internally persuasive for us and acknowledged by us, entirely different possibilities open up”. Analiese said that the eating disorder was a way for her “to keep going”. When she was in the anorexic “mind trap” she said all she could think about was “food”. We suggest that what Analiese was saying here was that she was using food to “survive” the “emotional shit” that came with being sexually abused. Yet at the same time Analiese ended up wanting to die, either through anorexia or hanging. From a Bakhtinian view, Analiese’s account graphically illustrates how, as part of a wider strategy of self-punishment and self-destruction, food refusal served to mark one’s lack of worth after being sexually abused. For Analiese, the eating disorder was just one of many ways of inflicting self-harm, with its primary signification and function being self-destruction. This is an active response rather than a passive reaction to sexual trauma, albeit a very painful one.

Analiese said **Image 2** was also about suicide being “intrinsically related to eating disorders”, emotions, the body and self-harm. Importantly, drawings can facilitate movement from internal to external expression, from silence to voice; they can access experiences that are simply beyond words (Hodge, 2014a). This is because visual technologies, and the images they show us, offer views of the world in very particular ways. Thus, a distinction should be made between vision and visuality (Rose, 2008). Rose (2008: 2) notes that “vision is what the human eye is physiologically capable of seeing...visuality, on the other hand, refers to the way in which vision is constructed in various ways...what is seen and how it is seen are culturally constructed”. As such, we consider that Analiese’s drawing makes use of colour when producing an image that represents an angel. Here, the angel is coloured in with a warm pink – a positive colour – with blue signifying divine power that pulls Analiese towards heaven, also
signified by a rainbow. Angels go back to ancient biblical times, playing important roles in the lives of humans, and continue to gain distinction through popular television shows, movies, books and spiritual activities (La Sosta & Sternberg, 2007). Thus, the functions of angels are innumerable. For example, angels are used to help, aid, support, facilitate, reflect, heal and inspire (La Sosta & Sternberg, 2007). Although these divine illuminating rays of the rainbow appear to guide Analiese on her path, we suggest that she is being pulled towards it and this indicates her inability to control the situation even if she is going “home”. Analiese has also positioned her body as sitting, and thus resisting, indicating she has some agency in her situation even if home or heaven is represented through the rainbow, which traditionally is seen as a symbol of hope. The halo, in this image, alludes to Analiese’s desire for purity (van Leeuen, 2008). As such, the images within the drawing appear to work together to create a story that impending death is strongly apparent and perhaps the angel is in fact the angel of death as a result of the pointy, darkened and gothic-like wings. Helplessness is readily apparent in art, as Gonick and Gold (1992) point out, where figures lack body parts to interact with the environment. In this way, the lack of facial features, including no eyes, mouth or nose, metaphorically illustrates a sense of being silenced and feelings of powerlessness.
When Analiese was asked to explain Image 2 she said that harming her body and starving it are “visual” things to get people “to notice” that something is “not right”. Analiese said she was just not “able to get the abuse out” of her “head” and “suicide” was the next step in trying to get someone to take her “seriously”. Therefore ‘being called home’ could also be considered a metaphor for death rather than happiness. She explains:

**Analiese:** I was obsessed with dying … So I think a lot of that suicidality came from just not being able to get the abuse out of my head. I think that they are very intrinsically related, the eating disorders and the emotions and the self-harm … it’s almost like cutting for me does provide a visual thing that I’m hurting. And even though it’s something that I try desperately to hide from people, it is still something that says that I’m hurting. The eating disorder, it’s the same thing but it’s a bit more open. Once you’ve starved yourself and
you’re skinny, people begin to notice that “oh maybe something is not right”
but when it comes to that point it’s almost like you feel so out of control that
no-one is paying attention to you, it’s almost like “well maybe if I kill myself
maybe then they’ll acknowledge what I’m going through”.

Here, Analiese’s internally persuasive discourse “awakens new and independent
words from within...it is not so much interpreted by us as it is further, that is freely,
developed, applied to new material, new conditions; it enters...into an intense
interaction, a struggle with other internally persuasive discourses” (Bakhtin, 1981:
345-6). Thus, from a Bakhtinian view, the eating disorder, sexual trauma and self-
harm were interconnected, thereby inscribing and visualising what was going on
alongside Analiese’s attempts to hide and reveal her struggle. People would notice
Analiese if her body was “skinny” and “acknowledge” what she was going through.
In this sense, Analiese’s obsession with “dying”, “cutting” and the “eating disorder”
could be considered to be “visual” ways of giving voice to her unspeakable emotional
pain. Our contention is that visualising of pain was a form of language Analiese used
to deal with the revulsion and horror of the abuse.

**Beyond Words: Using Drawing in Schema Therapy**

Drawing has been utilized both as the main focus and as an adjunct within a
range of therapeutic traditions, including psychodynamic psychotherapy (Egberg,
Sundin, Stahlberg, Lindstrom, Eklof & Wiberg, 2007), Gestalt Therapy (Amendt-
Lyon, 2001), Cognitive Behaviour Therapy (CBT) (Morris, 2014; Malchiodi & Loth
Rozum, 2012), Dialectical Behaviour Therapy (DBT) (Heckwolf, Bergland &
Mouratidis, 2014), Mindfulness-Based Therapies (Monti et al., 2006; Peterson, 2015)
and Schema Therapy (Van Den Broek, Keulen-de Vos & Bernstein, 2011; Van
Vreeswijk, Broersen, Bloo & Haeyen, 2012). Evidence suggests that trauma
memories are encoded as images (Arntz, de Groot; Kindt, 2005), which may incorporate visual, olfactory and kinaesthetic components (Kosslyn, Ganis & Thompson, 2001) and are by nature more emotionally charged than verbal accounts of the same experience (Holmes & Mathews, 2005; Holmes, Mathews, Dalgleish, & Mackintosh, 2006). The same areas of the brain are activated though visual imagery as in real experience, even when the person recognizes that the image is not real, thereby facilitating the processing of material in a manner which is superior to verbal reasoning (Holmes & Mathews, 2010). The use of drawing in therapeutic work capitalises on the potential of the human mind to process information more effectively in the presence of emotions evoked through images (Holmes, Lang & Deeprose, 2009; Arntz, 2015).

In the context of the research findings described in the first part of this paper, in this section we describe how drawing can be used within Schema Therapy for eating disorders, with a specific emphasis on Anorexia Nervosa. Schema Therapy integrates elements of experiential, interpersonal, cognitive and behavioural change work. This approach has a strong emphasis on emotional processing and increasing interpersonal connectedness through a focus on the therapeutic relationship (Young, Klosko & Weishaar, 2003). Preliminary studies suggest that Schema Therapy may be suitable for the treatment of eating disorders (McIntosh, Jordan, Carter & Joyce, 2012; Munro et al., 2013; Simpson, Morrow, van Vreeswijk & Reid, 2010; Simpson & Slowey, 2011). The therapist deals with underlying maladaptive belief systems through identifying and working with the different parts or ‘sides’ of personality manifested by the patient. The process of identifying, labelling and working with each of these parts (or ‘modes’) is an integrative process, which facilitates acceptance of previously rejected aspects of the self (e.g. due to high levels of shame, avoidant
coping). Within the therapeutic process, the specific techniques or strategies chosen by the therapist are dependent on the current mode that the patient presents in. For example, the self-critical or ‘Punitive’ mode ‘voice’ that often underlies an eating disorder may present in session as a tendency to criticize themselves harshly, representing internalized messages from childhood that are derived from multiple sources (e.g. culture, social media, abusers, parents, religion, peers, bullying). The ‘child’ modes represent the needs and emotional and somatosensory experiences of the client (including vulnerability, shame, loneliness, helpless) and are often the target of criticisms from the Punitive mode. The coping modes, are the survival states and coping mechanisms (including eating behaviours) that have developed in childhood or adolescence to escape from underlying experiences of vulnerability and/or emotional distress and block emotional needs and emotions, which are perceived to be ‘unacceptable’ to others. These coping modes (and attendant eating disorder symptoms) may therefore play a protective function in the short-term, whilst further perpetuating the person’s problems in the longer-term by preventing them from accessing healthier aspects of themselves that could potentially enable them to get their emotional needs met in an adaptive manner. An important goal of Schema Therapy is to strengthen the adaptive Healthy modes (balanced and embodied healthy adult and child modes), whilst healing the wounds associated with the child modes (Simpson, In Press).

Drawing on its capacity to access preconscious material (Aron-Rubin, 2011) art can play a distinctive role in the context of Schema Therapy. Through the act of drawing the different ‘sides’ of the self, modes which have hitherto been experienced as ego-syntonic and fused to the patient’s identity become differentiated and de-fused. This process facilitates recognition of all of the different parts that make up their
whole ‘self’, and in particular integrates the more neglected or avoided aspects of the self (e.g. traumatized or abused parts of the self, that have become ‘embodied’ or somatised, but not directly expressed). Childhood trauma is commonly encoded in the form of implicit somatosensory fragments (i.e. images, physical sensations, tastes, smells) that may not be directly accessible through standard talking therapies (van der Kolk, 2014). In eating disorders the trauma is often described as a combination of a deeply embodied ‘felt-sense’ of shame or ‘dirtiness’ and visual images (Simpson, In Press). In Schema Therapy, drawing has been shown to facilitate access to emotional states, which may be inaccessible through verbal dialogue (Van Den Broek, KeulendehVos & Bernstein, 2011). In addition, with the therapist’s guidance, drawing can enable the patient to begin to conceptualise their own complex intrapersonal processes and to begin a ‘virtual dialogue’ between the different modes or parts of the self.

**Drawing in Schema Therapy: a descriptive case study**

Mariana was a woman in her mid-thirties who first developed Anorexia Nervosa (binge-purge subtype) at the age of 13. She presented with symptoms of complex trauma; dissociative episodes, severe flashback memories and nightmares, psychotic episodes, which involved hallucinatory images of the abuser, altered self-perception, body perception distortion, derealisation and depersonalization. She had attended several inpatient and outpatient treatments prior to starting Schema Therapy. She had survived several serious suicide attempts and physical complications, which included the loss of her large bowel due to laxative abuse, osteoporosis and kidney failure. During childhood, Mariana experienced sexual abuse by an uncle intermittently for five years, in the context of an emotionally inhibited family. She was discouraged from expressing her needs and emotions and seeking support within her family, and therefore kept the abuse a secret until she sought therapy for her
Anorexia Nervosa as an adult. She described feeling ‘worthless’, ‘not good enough’ and ‘dirty’, with a frequent urge to shower in order to ‘wash the feeling of grottiness off my skin’. She had received explicit consistent messages from her father around the negative consequences of eating and gaining weight, which was reinforced by ballet teachers. Mariana experienced Anorexia Nervosa as a ‘substitute identity’, which had provided her with a sense of control, predictability and certainty over her often abusive and unpredictable childhood environment. Weight loss led to a sense of pride and achievement, and functioned as a safe way to express anger and frustration whilst minimizing the risk of ‘burdening’ others with her needs and feelings, and subsequent rejection. Ultimately, her Anorexic coping modes provided a tangible and socially acceptable way to improve her sense of self-worth, and the predictability and certainty of day-to-day life.

In the first phase of Schema Therapy, the emphasis is on facilitating emotional regulation through identifying and validating unmet childhood needs and associated emotional reactions by creating a safe and attuned therapeutic rapport. Drawing functions as a powerful means of shifting the experience of self from fragmented and disconnected to integrated and whole. The process of differentiating the parts (modes) leads to integration, whereby the patient moves from a simplistic perception of their identity as defined by their Anorexic coping modes, to a more complex and authentic sense of self (Cruzat-Mandich, Diaz-Castrillon, Escobar-Koch & Simpson, 2015).

In the case of Mariana, her childhood experience of self as vulnerable, fearful and ashamed had been suppressed due to her perception that emotions were a sign of ‘weakness’, placing unacceptable strain on others. She had therefore used eating disordered behaviours (dieting, calorie counting, excessive exercise) to escape the physiologically embodied sensations of trauma. In Image 3 Mariana depicts the
‘banished’ child mode that holds the emotions associated with childhood sexual abuse and emotional neglect, trapped in a cage, unheard, unloved and powerless. Through drawing, she was able to access and express her healthy emotional needs to be listened to, to be treated with respect, to be loved, and to be free.

**Image 3**

In **Image 4**, Mariana illustrated the inner torment she suffered at the hands of the internalized ‘Punitive’ mode that carried the trauma messages associated with childhood abuse and neglect. The little red men represent the “evil messages” that her uncle would use to make her feel responsible for the abuse. She described these as sometimes manifesting as a ‘voice’ and sometimes as a clear ‘flashback’ image of the abuser, telling her that she was bad, unlovable, worthless, dirty and a child abuser.
Imagery exercises were used to create a sense of safety or therapeutic “window of tolerance” (Siegel, 1999), by providing a soothing alternative to Mariana’s usual states of hyper- or hypoarousal with a view to creating conditions more conducive to emotional processing. In therapy, Mariana was helped to create an image of a ‘safe place’, driven by her individualised needs around safety. In session she was helped to create a safe-place image, and then to close her eyes and imagine herself within the image, whilst noticing the ‘felt-sense’ interoceptive [body-based] experience of being in that place in as much detail as possible. She was asked to draw her safe place for homework, to further develop the sensory details, drawing on her own intuition and imagination. She was reminded that the intention was to access and express her internalized bodily experience of the safe place using colours and shapes, as opposed to an opportunity for her perfectionistic side to express itself. This drawing was then utilised in future imagery sessions as a way of connecting to her safe place at an interoceptive level within mental imagery, particularly in the context of reducing hyperarousal associated with childhood trauma images. Image 5 is a depiction of
Mariana’s safe place, whereby a force-field protected her and the therapist from the harm associated with intrusive images of childhood abuse and abandonment and ongoing criticism from the internalized Punitive Mode. In this image she described feeling ‘cushioned’, protected, nourished, safe, light, alive, free and accepted.

Image 5

In the change phase of therapy, drawing was also used to increase insight into the role of coping (‘survival’) modes (as manifested by dysfunctional eating and interpersonal coping behaviours) and their tendency to perpetuate the very problems that they were designed to escape in the first place (i.e. increasing social isolation, creating distance and strain on interpersonal relationships, destroying physical health). Through drawing, the ‘character’ of the coping mode can be portrayed through facial expression and features, clothing, colour, and size. Drawings are also used to depict interactions between the modes, such as the Punitive mode punishing the ‘Vulnerable’
(child) mode, or the Coping mode acting as a misguided ‘friend’ toward the ‘Vulnerable’ (child) mode whilst preventing them from getting their emotional and physical needs met. Drawing can highlight the possibility that the coping mode might not be as adaptive as they had previously assumed and facilitate the process of de-identification and/or de-fusion from this aspect of self. This process is crucial in the treatment of eating disorders, where the eating behaviours are often experienced as highly egosyntonic and representative of one’s ‘true’ identity.

The possibilities for using art in Schema Therapy are limitless. With Mariana, drawings were used to develop an image of the ‘Healthy Adult’ self that was able to protect the ‘Vulnerable’ (child) mode through the use of creative imagination – including the creation of an omnipotent physical presence, shields, force-fields, secret passageways, and powerful statements. In order to develop images associated with building a ‘Healthy Adult’ side, she was encouraged to experiment with different postures, facial expressions, gestures and to try slowing down her breathing rate. In addition, she was encouraged to access feelings of anger or irritation associated with the injustice of her experiences. Over time, this enabled her to move from the embodied/sensory experience of victimization to that of a ‘Healthy Adult’ self - empowered, safe, and connected. We also used drawings to ‘shrink’ the Punitive (internalized) mode and give it a posture and expression that diminished its perceived power, whilst increasing the size and power of the Healthy Adult mode. Caricatures (drawing on aspects of politicians she disliked) were used to poke fun at the Punitive Mode and diminish its credibility. The drawing exercises were often carried out for homework to reinforce and expand on the in-session experiential change work (i.e. imagery rescripting and chair work). Over time, successive drawings of the Healthy Adult mode can help those with eating disorders to personify and elaborate on this
‘new’ side of themselves, to internalize and embody it, with the ultimate goal of overseeing and regulating all of the parts of the self, with the goal of greater integration and well-being.

**Conclusion**

In this paper, drawings placed the analytic lens upon the social intersection between “what is seen” and “what is felt” (Cross et al, 2006). In doing so, we found that women’s distress, played out through the body in the form of self-harm and disordered eating practices, was an enactment of their engagement with certain discourses and practices rather than a reaction triggered by experiences of child sexual abuse and sexual trauma.

An eating disorder was shown to be one way of inflicting self-harm with its primary function being self-destruction and even death. Painful thoughts and emotions could be suppressed and replaced by eating disorder practices. The women starved their bodies as a means of communication when words were not available. The visualization of pain produced through harming the body was a form of language the women used to deal with the revulsion and horror of the abuse. Thus, in Bakhtin’s terms, the women’s bodies were sites of protest through grotesque performance that suggested some agency to negotiate their lives.

This paper has also demonstrated the significant potential of drawing in therapeutic change work with eating disorders. The case study of Mariana has illustrated some of the ways in which this work can take place as an adjunct to imagery rescripting in the treatment of an eating disorder and childhood trauma. By using drawing in eating disorders schema therapy, space is created for individuals to express their interoceptive experiences and emotions. We encourage practitioners to use drawing in schema therapy when working with eating disorders, as it has the
capacity to make the invisible inner thought, vision or experience, visible by taking advantage of the human capacity to process information more effectively in the context of images (and associated perceptual and somatic experience). In this way, complex layers of meaning can be unraveled.

References:


Carretero-García, A., Planell, L. S., Doval, E., Estragués, J. R., Escursell, R. R., &


Dialogism. 1, 74-91.


The captions for Image 1: 'Analiese' - a self portrait; Image 2: "The angels are calling me home"; Image 3: 'Banished' child mode; Image 4 'Punitive' child mode; Image 5: Mariana's 'safe' place