THE USE OF GUIDED FANTASY IN ART THERAPY WITH SURVIVORS OF SEXUAL ABUSE


The context in which the following session took place is an Eating Disorders Unit that is part of a London teaching hospital. Patients admitted for treatment of both anorexia nervosa and bulimia nervosa remain as inpatients for between 5-8 months on average and participate in a wide range of therapeutic activities of both a cognitive-behavioral and a psychodynamic approach.

Art therapy is a very significant part of each patient's treatment, and the approaches adopted by the therapist vary according to the patient's capacity to use the techniques that will in turn relate to the stage in treatment or recovery. At the initial stages many patients, particularly the anorectic group, work better within the framework of a given theme, whereas, with an increasing sense of autonomy and self-direction, the patient's confidence to allow greater degrees of spontaneity and decision making means less dependency upon the therapist's direction.

The patients attend a weekly group and paint together for a set period of time, after which they form a verbal group that borrows much in style from group-analytic techniques. In particular there is a de-emphasis on allowing each member of the group to have an "equal share of the cake," but rather the group is encouraged to make use of just a couple of images that then become a metaphor for the whole group to work with. This style in itself creates certain dynamic issues, such as competitiveness, fear of asking to take up group time, envy of those who do so and so on. Part of the work of the group is therefore to work with these issues, which may often arise before a member has even begun to explore her image.

I mention this because in the session I am about to describe it will be noticeable that there is a distinct lack of these issues being addressed and an attempt by the group to adapt the usual style into one that may prevent conflict among members. It is fair to state I have also edited the session in order to present individual themes.

Much has been written on the possible relationship between the eating disorders and sexual abuse (Finn, Hartman, Leon & Lawson, 1986), but the current literature suggests that in fact the incidence of sexual abuse is no higher in this population than in any other psychiatric population although, as one would imagine, there is a significant increase in the incidence of sexual abuse if one compares a psychiatric population to a normal group.

However, there exists a subgroup of eating-disordered patients for whom this does not hold true and it is this group I will be referring to in this paper. At the time the particular session to be described took place, all the patients had been victims of sexual abuse perpetrated by their biological fathers or their stepfathers, with one by a brother and one by an uncle. Although in this instance all the abusers happened to be men, it should be remembered that it is certainly not always the case. In my clinical experience, I have found the incidence of female perpetrators reported to have become increasingly common. Many significant social factors inhibit the disclosure of this, as was so

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well described by Welldon (1988). She described the
way in which women are regarded as committing two
criimes, the overt abuse and also a rejection of their
traditional role as women.

The group of patients discussed here differs some-
what from the two psychiatric classifications of An-
orexia Nervosa and Bulimia, and have been described
in Lacey and Evans (1986) as suffering from a Multi-
Impulsive Personality Disorder. The patients pre-
sented with their primary complaint as bulimia, but in
fact differ significantly from the more common group
of bulimia sufferers in that they demonstrate a wide
range of impulse disorders as well as their chaotic
eating. Frequently these include alcohol or drug
abuse, self-mutilation, shoplifting or sexually disin-
hibited behavior that causes them distress. In general
their lives are in far more disarray and chaos than the
Uni-Impulsive group of bulimia sufferers, whose
character structure is more of a neurotic type. These
women often have jobs and relationships intact.

Those with more personality disturbance often
come from highly dysfunctional families, in which
boundaries and roles are unclear and there is a high
incidence of other impulse disorders, for instance,
alcoholism in one of the parents. It is within these
families that there is a noticeably larger incidence of
sexual abuse. It is a very complex point for discus-
sion—why these particular women’s pathology has
resulted primarily in an eating disorder. However,
this is a debate for another arena.

Although much of the material from this group
also relates closely to these patients’ eating disorders,
I have purposefully selected the salient points that
specifically could be seen to relate to the theme of
sexual abuse or, more accurately, ways in which suf-
ferers have developed particular defenses, although,
of course as one will see, there is considerable overlap
in certain issues.

The session that follows involved the art therapist
(AT) telling the group a guided fantasy and inviting
the participants to make some image connected to
their responses. The fantasy was as follows.

It is an early spring evening and you decide to go
for a walk along a path that runs through the forest. It
is warm and there is a gentle breeze. You reach a
sandy cove and see a rowboat. You get in it and
slowly row across the river to a small island ahead.
There you row up onto the beach and climb out of the
boat. Ahead of you stands a cottage with its front door
wide open. You go inside and find yourself in the
living room standing in front of a large fireplace with
a mantel above it. On the mantel stands a photograph,
which you look at. (Pause) Then you overhear two
voices talking in the next room and you listen to them
for a minute or two. (Pause) One of them leaves
through a back exit, and you decide to knock on the
doors and meet the person who remained. That person
says “Come in,” which you do.

Who is this person? And what is said to you?
(Pause) At some point you decide to leave. What do
you say to the person before you leave? (Pause) You
walk back to where you left your rowboat. The
weather is a littler cooler now and the sun is beginning
to set. Sitting by the boat is a fisherman who speaks
to you, saying something important. Then he gives
you a box containing something. You get into your
boat and row off across the river. When you reach the
sandy shore you stop and open the box to see what
is inside. (Pause) Then you climb out of the boat
and walk back up the same path you originally came
down through the forest. After a short while the path
leads you back to this building and you return to this
room.

At the end of the guided fantasy, the patients were
asked to paint or draw any images that came to mind
associated with the story; they were given half an hour
for this. At the end of this time the group gathered
together with their work open. I have selected rele-
vant material from the discussion that followed. Pa-
tients’ names and any potentially identifying features
have been changed to preserve anonymity.

Susan: (Her picture was of a single large black X
painted thickly across the whole sheet of white pa-
per.) “I’d like to start. I didn’t want to do this at all.
In fact I stopped listening to you.” (Speaking to the
therapist)

AT: “So perhaps that X is a message for me?”

Susan agreed. Other patients asked Susan more about
her reaction.

Susan: “It wasn’t the story I minded; I don’t even
know what the story was; I wasn’t listening.” (Looks
at therapist again) “It was the idea of being told what
to do.”

Susan explained how she found herself having to
resist being directed and had found the experience of
a guided fantasy as massively controlling. One patient
challenged her, telling her she has missed yet another
opportunity to make use of this session because she
(Susan) always refused to be controlled or led. Susan
acknowledged this, but felt that she would rather con-
tinue to make that choice than to “submit” to others.
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Jenny: (Her picture was of a woman holding a book with children sitting around her feet.) “I also felt a bit like Susan. I didn’t like being told what to think either.” She said of her picture, “I just remembered being at nursery school being read stories by our teacher after lunch.”

Another patient pointed out that the teacher in the picture had the same style of blond hair that Jenny had. Jenny said, “I thought I was one of the children in the picture, but maybe I’m actually the teacher.”

After more discussion the therapist suggested to Jenny that perhaps her way of dealing with her wish not to be told what to think differed from Susan’s way. She may have identified herself with the storyteller (i.e., the teacher) rather than the listener in order to feel a greater measure of control. Jenny’s picture appeared quite benevolent and gentle, but there was a black shadow effect, which the art therapist asked Jenny about.

Jenny: “I’m not sure, but I feel like there’s something sinister going on as well, even though it all looks totally innocent.” She was encouraged to free associate to her image, and her thoughts became increasingly disturbing, with violent content.

AT: “Perhaps there is a good reason why at this stage you need to feel that you are the one in control and not someone else. On one level you say the picture looks quite innocent, but maybe part of you is frightened that underneath that superficial appearance something quite different may be going on.”

Jenny nodded in agreement. The therapist thought that at this stage Jenny may not be ready to own any of the violent cruel thoughts that she had attributed to external objects, that for now her violent rage was too scary for her to assimilate and had to be split off. It seemed sufficient to acknowledge her fears of these aspects of other people’s motivations toward her, from which she had to protect herself. However, at a later stage Jenny would need help in recognizing how she has internalized a cruel sadistic figure that was now actively operating against herself, particularly in her extremely self-destructive behaviors.

Tina: (Her picture was of a man and a woman fighting with knives.) “My picture is from the scene in the cottage. When I went into the other room, I found this man and we both had kitchen knives (she laughed with embarrassment) and we didn’t say anything to each other, but we just started fighting. It was like a sword fight but with small pathetic knives.”

On the picture was also a gun in a box; she said this is what she had found in her box and, as she got into her rowboat and had opened it, she had shot the fisherman.

Tina had made the picture using a great deal of energy, choosing wax crayons she had pressed deeply into the paper, actually ripping through the paper in one part. Her colors were bold and she had left little space on the sheet. Other patients commented on the aggressiveness of her style and of the content. Tina agreed that she felt very angry but did not know what about. When she was asked to retrace her thoughts from the story, she recounted having imagined overhearing a man and a woman in the cottage shouting at each other. The woman was being threatened in some way by the man and she, Tina, had rushed in to fight the aggressor.

It appeared possible that the woman-victim represented a self-image of the once defenseless Tina and that she now had access to a protector part of herself whose aim it was to defend her own vulnerable self. But this caretaker self was also driven by her violent feelings toward her abuser, which led her often to feeling quite out of control.

Some discussion followed about the ways in which aggression is so negatively framed and yet, when channelled safely, how it can be utilized. The therapist was careful to acknowledge Tina’s right to her aggressive feelings, which meant balancing interpretations to include acceptance of aggression as a rightful emotion, while reinforcing the danger to both Tina and others if her actions were not constrained.

Kerry: (Her picture was of a doll-like girl lying in a large black coffin.) She followed Tina by saying about her painting, “This is what I found in the box the fisherman gave me. It’s a doll that looked just like me. I felt really scared; it was like he was practicing voodoo or something.” (She spoke nervously, half joking.)

She went on to free associate to her image encouraged by other patients’ questions and her thoughts led her in the direction of being put in a box unwillingly, which she linked to death (hence the coffin). The further associations led to a link between box and bed, and she openly acknowledged that her image reflected her memories of having been sexually abused. Being controlled on some level meant psychological death to her.

AT: “I wonder if you also had some response to being told a guided fantasy and may have also felt
controlled by me? Although in your picture it is the fisherman who is controlling you by putting you in a box, perhaps it may feel that having your mind directed is similar to having your body controlled?"

The therapist was thinking here about Kerry’s tendency to think concretely and not symbolically. As with many of these patients, mind and body have not become fully differentiated, which results in their great anxieties about containing difficult thoughts and feelings. If these are not sufficiently experienced symbolically as separate from action, there remains the ever-present danger of a violent thought being equal to a violent action.

Difficulties in this developmental phase are, of course, exacerbated by growing up in families who also have not been able to differentiate thoughts, wishes or desires (for instance, incestuous desires) and from carrying these out in action. As children, therefore, many of these young women received little or no modelling by parents being able to contain something in their minds without having to act upon it; one automatically followed the other. This lack of mental space that could allow things to be thought about is related to disturbances in the processes of symbolic thought and that in turn related to concepts of separateness and differentiation. The compulsion to act rather than think leads to the vast array of acting-out behaviors these patients demonstrate, or alternatively to excessive use of defenses to contain potentially out of control behavior. The patient feels certain thoughts, such as anger toward someone, will result in a physical attack or worse.

Through discussion concerning Kerry’s picture, the therapist suggested that a number of the group seemed to share a similar response to the form irrespective of the content of the session, and that to go along with the guided fantasy may have felt like submitting to the will of another person. Some members of the group seemed to be conveying that to stay in control felt like a matter of life and death and therefore had to dominate their total functioning. One way of surviving this session had been to mentally counteract the therapist by not listening, or changing the story.

Liz followed this discussion by volunteering to explore her painting, which was of a female figure perched on top of a single mountain on an island, up among the clouds. She identified with much that had already been shared, saying that she too had decided to take a different route when listening to the story and, instead of landing on the island, she had rowed on in her imagination to another island on which there was this large mountain.

Liz: "I heard you (the therapist) talk about overhearing the people in the next room and I thought how glad I was not to be anywhere near them and involved with their petty problems."

When asked to fantasize what would have happened if she had got off the boat at the first island and met one of these two people, she responded, "I imagine they were husband and wife quarrelling and would have been glad to find me there so that I could have sorted out their argument for them, which is the last thing I would have wanted to do. So I’m glad I went off to my mountain!"

Another patient asked Liz if it was lonely up there, and another commented on how Liz doesn’t join in much in the psychotherapy group except for acting as a co-therapist. The art therapist suggested that Liz may expect that getting involved with people means she is going to be used by them to fulfill their needs in some way. (She was thinking of Liz having to solve the couple’s row, and her experience within her family.) Yet, the therapist continued, when she does participate in the group, as pointed out, this seems to be the only role she is familiar with, and so automatically takes it on. It seemed that Liz was unable to change her way of relating or of accepting others relating to her and so had to escape.

It appeared that Liz had little concept of people being of any help to her or how she may have any of her own needs fulfilled. The positioning of herself on top of the mountain may have reflected her defensive omnipotence. That in some way she could look down on these arguing mortals while she was up among the clouds in a god-like position. Yet this position isolated her from the group who otherwise could possibly be of help to her. On discussion, Liz agreed she did feel lonely “up there,” but was scared to climb down. She conveyed her deep sense of mistrust in relationships and her long-term reliance upon a false sense of superiority and the resulting hollow triumph.

The recognition of Liz’s defense position allowed other patients to identify with this and to examine how this may work against them in preventing closer trusting relationships to develop with each other and with the staff. Marjory then said she would like to look at her picture, which was a pencil sketch of the fisherman handing her the box that had a yellow halo surrounding it. The stick figure image of herself holding
her arm out to receive the box had a two-inch gap between her hand and her arm. Her other hand and arm were intact.

Marjory said her picture was linked to what we were talking about, her difficulty in receiving help. She said she thought the box contained something really good in it (hence the halo) and, although she wanted to take it, something stopped her. She knew that the help on offer here was only touching the surface and that she wasn’t allowing it to penetrate (her word). She heard herself use the word penetrate and followed this with, “I’d understand if it was only bad things I wasn’t going to let touch me, but that’s not the case. I genuinely thought the fisherman was a kind old man who was giving me something magical that I wanted, so it doesn’t make sense—why shouldn’t I let myself have good things?”

Another patient said, “Maybe you can’t tell the difference,” and another said, “Maybe you don’t feel you deserve them.” Marjory considered these ideas and said, “These both might be right, but it’s almost as if I put a total ban on anything getting to me, even food I suppose.”

AT: “Perhaps you too can identify with the theme that has been so striking in this group, of being controlled. I wonder if to receive anything at all from another person may feel like being controlled and overwhelmed by their thoughts as if you might not be able to retain your own sense of self. That might make even receiving help dangerous.”

The therapist also considered the role of envy in this patient’s refusal to accept good from others whom she perceived to have more good things to offer than she had. To receive would therefore also inflict the narcissistic injury of forcing an awareness of her state of deprivation as compared to the other person’s fullness. But at this stage it seemed of primary importance to work with Marjory’s need to feel she could preserve her sense of autonomy and separateness while taking something in to herself from another person, in this case an interpretation.

AT: “One important difference now is that you as an adult can choose what to take in and what to reject, whereas as a child you were in much more of a powerless situation. Perhaps sometimes now it still feels the same as in the past, in which case you would understandably try to find a way of preventing things getting in.”

The next patient to share her picture was Diane, who had torn out pictures from magazines in the department, all of idyllic scenes—the sea, a country cottage, a beautiful garden. There were no people in the pictures.

Diane: “I agree with a lot of Marjory’s picture. I also didn’t like the guided fantasy. When you (speaking to the therapist) told me I had to row the boat I wanted to go swimming and I didn’t want to go to the cottage you said I had to go to. The only nice part of the fantasy was that I found my grandmother’s picture there and then she was in the room. She’s actually dead. But she smiled at me and we just sat there in silence together.”

On examining this, it appeared as if any of the therapist’s verbal interventions had almost felt like an irritant under Diane’s skin. Her choice of pictures was an attempt to wipe out human interaction, words, and find the stillness and peace she had had momentarily with her grandmother. As she described this, the therapist’s countertransference made her begin to feel like an imposition in Diane’s life! The therapist began to feel guilty for having disturbed Diane’s peace and to not let her be. This led to her considering whether Diane herself had perhaps been made to feel an imposition in her own family, whether she (Diane) had felt she had disturbed the peace by coming along. The therapist put this to her.

Diane: “The only way I would have been acceptable was if I played the game the right way. It wasn’t that I was an imposition or disturbed their peace just by existing; as long as I couldn’t speak and disagree with anyone or anything I was o.k. I only became not o.k. when I started to think for myself. That wasn’t on.”

AT: “So the only times of peace you recall were when you didn’t assert yourself as an independent person.”

Diane: “Yes, but I’d have had to stay six months old forever to keep the peace. It’s funny because when Simon was abusing me for all those years he swore me to silence.”

Another patient said, “No wonder you associate words with causing trouble.”

Following this, Eve pushed her picture forward. It depicted two men, one on each side of the page with a thick black line down the middle. One had horns and a tail and the other a big smile and a tennis racket.
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Eve: "When you said I could overhear two people in the cottage, I heard two men, these two. One sounded nice and the other one sounded really evil. That one was my father and he left through the back door so when I went in I met the nice one who was friendly to me. But then it got more like a bad dream because when I met the fisherman, he was the nice man, but he had a false beard on and I didn’t know why he should be in disguise. (After some discussion, Eve thought that the nice man also represented her father.) I think they’re both my father; it sounds odd I know after all the things he did to me, but there were times he really was very nice to me. We did play tennis when I was little. He was like a Jekyll and Hyde character."

AT: "It sounds as if you feel you have two fathers; perhaps you wish that were the case because then at least you could preserve an image of the good one that you would wish for. If the two pictures come together it means that the man who you have cared about and wanted as your father would be the same person who treated you in such an awful way."

Eve: "He really does seem like two different people. When he’s being kind I don’t for a second think that he could behave the other ways when he turns."

The other patients picked up on Eve’s description of the fisherman actually being the nice man in disguise, and one said to her, "That didn’t sound much like the fisherman turning, but far more premeditated than that."

AT: "This division you’ve created, Eve, is also something you know about within yourself, as one side of you has also been very nice and good at home while another secret side of you has been out to wreck your own life. Perhaps it’s as difficult to accept the different parts of yourself as much as in your father."

(The therapist was thinking about splits in object relationships reflecting the splits in the self representations. This is explored indepth in Bachrach and Levine, 1986.)

Other patients joined in at this point, identifying with the different opposing feelings some of them held toward their abusers, sometimes loving feelings, at other times overwhelming hatred and rage.

The last patient to speak was Karin. Her picture was of herself behind bars in prison with a hangman’s noose at the side of the prison. She said of her reaction to the fantasy, "I overheard a couple talking in the cottage about how they mustn’t let their child go out alone on this island because they had heard that there was a maniac on the loose, a child killer or molester."

Karin had felt immensely guilty, identifying with this maniac. The gift the fisherman had given her was a gun with which she was meant to kill herself. The picture was of her awaiting execution in prison, which she felt she rightly deserved. Much of Karin’s behavior was severely self-punitive and guilt-induced although she was unaware of the origins of these feelings. Another patient asked her more about her identification with the child molester/killer. As Karin spoke, she heard how her fantasized behavior reminded her of her uncle’s actual behavior. She began to see that she had unconsciously identified with her abuser and so carried the guilt for the abuse. The therapist thought that Karin’s guilt was also connected to her perception of voluntary participation or, worse still, invitation, and that a great deal of work was needed in these areas. Karin made reference to this by saying perhaps she deserved a death sentence because she did in fact hate young children and saw them as highly seductive and corrupt.

AT: "Perhaps you are identified with both the child victim and the adult-perpetrator, but at this point you feel like punishing the child-victim inside you instead of taking care of her because she’s been hurt. It seems you are carrying the guilt of the perpetrator, who was not you, and the undeserved guilt of the child who was you."

Karin expanded on her fantasy that the child was in danger of being abused, but as she had only just arrived on the island, why should she feel responsible? If the child had already been abused, the only other people on the island were her parents. Through the fantasy, Karin was attempting to extricate herself from the responsibility for the crime and locate it where it belonged.

The group ended with Karin’s painting.

Conclusion

This paper has attempted to select particular parts of an art therapy session, using guided fantasy, to highlight some significant issues in working with survivors of sexual abuse. Of course, there are a great number of other crucial issues, not referred to here, that regularly emerged with this client group. There was, for instance, a noticeable absence of images of
discussion about mothers, a point of interest in itself, as the actual absence of the mother when she was needed originally has often been noted in cases of father-daughter incest. The resulting rage toward the absent mothers may be demonstrated by her being "wiped out" of the picture altogether. Other variations on the relationship and attitude toward the mothers have been examined by Jones (1991). These dynamics will often become clearer in the transferential relationships with female staff.

The issues that did arise in this session, however, are fairly representative of a number of themes I have found to emerge frequently among this population. However, not having used this particular technique of a guided fantasy exclusively with a group such as this before, what came as some surprise to me was the strength of so many of their reactions to the form of the technique as opposed to the content, particularly highlighting issues of control.

I will end with a quote from a survivor, described by Bass and Davis (1988), that indicates the effects of growing up in a chaotic environment: "I have a tremendous attachment to things going my way. It feels like I'm going to die if I don't get my way. There are a lot of small, everyday interactions that make me feel tremendously out of control."

References


