Drawing on Dreams:
An Art Therapy Contribution to Group Dream Work

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A Thesis

in

The Department

of

Art Eductation and Art Therapy

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts at
Concordia University
Montreal, Quebec, Canada

March 1999

ABSTRACT

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Ullman's model of group dream work (1979, 1988, 1990), developed outside the clinical setting, is identified as a safe and effective means of cultivating self-understanding. This approach organizes the participation of all members in promoting one dreamer's discovery of the dream's metaphoric representation. The integration of a drawing response to the target dream represents an art therapy contribution to this approach to dream work. The individual drawings extend the possibility for each member to recognize projective and introjective resonances with the dream, thereby enhancing self-awareness. The model's fundamental endorsement of the dreamer's control over the process, and his or her authority over the dream's meaning, suggests that this approach, although not intended for clinical use, may be potentially beneficial for patients diagnosed with an eating disorder, given an underdeveloped sense of agency specific to this population. The collected data offers evidence of this hypothesis. Discussion of selected clinical illustrations provides support for positioning this integrated model at the end stage of treatment, rather than the beginning, as was the case in this study. It is suggested that there may be advantages in modifying the placement of the drawing response, as well as its application within the dream work. Consideration is given to the adaptation of this integrated model of dream work and drawing for use by more severely symptomatic patients.

Dedication

This thesis is dedicated to the memory of

my mother

Sophie Jastremski
1919 - 1998

and
my sister

Bernice Ilnicki
1952 - 1980

Acknowledgements

I extend my sincere appreciation and gratitude to the following individuals:

Pierre Grégoire, for optimism, encouragement and unwavering containment in his supervision of this thesis;

Tore Nielsen, for structuring feedback;

Alan Siegle, for unknowing inspiration;

Montague Ullman, for sharing his visionary dream sense.

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Introduction

This thesis proposes a reappraisal of working with dreams in a clinical setting where the therapist is the dream expert. Methods of working with dreams within individual and group formats in verbal and art psychotherapy are reviewed. These methods are contrasted with the growing lay interest in dreams over the past thirty years which has stimulated the development of a variety of non-traditional approaches to dream work. Developed outside the clinical setting, these approaches now provide alternate models to the accepted notion of "therapist as dream expert".

Broadly speaking, in non-clinical models with two or more participants, the role of the "expert" has been redefined to that of a "guide" to the dreamer. This modification renders the therapist expert only in the application of the prescribed model, rather than as arbiter of the dream's meaning. This shift in the paradigm of dream work necessarily repositions the dreamer to a stance of authority vis-à-vis the dream's interpretion.

A well-established model of group dream work, developed by Montague Ullman (Ullman, 1979; 1988; 1990; Ullman and Zimmerman, 1979) is proposed as one which brings together the notion of dreamer-as-expert and group dream work as a socializing, therapeutic, albeit, non-clinical activity. This model reflects Ullman's thinking about the inherent power of acknowledging the undeniable relatedness of human experience (Ullman, 1960).

Impaired mental functioning unavoidablely engenders some degree of isolation and distance from others , thereby contributing to the individual's sense of disconnection from him or herself. This phenonmenon is directly confronted in Ullman's model by virtue of its participants' collective exploration of unconscious concerns about the social matrix to which they

belong. If this can be a real option, then to introduce such a model into a clinical context can be a means through which the patient can address and ultimately improve an impaired sense of agency. Additional benefits may include the development of creativity implicit in the attempt to understand the dream's metaphoric language and variances in the visual dialects particular to each dreamer (Greenberg & Pearlman, 1993).

The integration of a drawing response with the Ullman method was intended to extend the group members' opportunity to identify their individual projective and/or introjective resonances with the target dream. Compared to a verbalized projection, a non-verbal response may reveal an affective component that might otherwise remain unelaborated or unstated. The image documents the group member's feelings and thoughts specific to the concerns raised in the dream. As such, it reflects a piece of the mosaic which is the shared social context of the dream group.

Given the non-clinical origin of this approach to working with dreams, one might well question the notion of introducing this hybrid model within a clinical setting. However, because the goal of treatment is the individual's discharge from hospitalization or out-patient care, these "patients", on their way to becoming fully functioning "members of the community", need to become competent care-takers in the on-going maintenance of their individual psychic lives.

This thesis proposes that the application of this integrated model of group dream work can be a potentially beneficial and meaningful undertaking for certain patient populations. For a variety of reasons elaborated further below, those diagnosed with an eating disorder were thought to potentially benefit from such an approach. The validity of recent feminist contributions to our understanding of the etiology of eating disorders

(Orbach, 1986; Kearney-Cooke, 1991; Robertson, 1992; Fallon et al., 1994) suggests the appropriateness of this horizontal (i.e. essentially leaderless) approach to "dream appreciation" (Ullman & Zimmerman, 1979) rather than dream interpretation. The emphasis on a non-invasive, respectful attitude to the dreamer's authority over the dream maximizes this population's implicit need for self-definition, without the interference of experts and interpretations.

The selected clinical illustrations are intended to demonstrate this particular group's response to the use of drawings and Ullman's model of working with dreams. The illustrations also provide a basis for discussion of what makes it important to apply this model at the end stage of the therapeutic continuum rather than at the beginning of treatment, as was the case in this study.

This conceptualization of dreamwork reappropriates the dream to every day life as a useful and endless source for reflection on the potential deeper meanings of waking experience. An individual with a history of functional impairment who has developed a link to his or her inner life through dream appreciation may be better positioned for continued success following the termination of treatment.

The use of a drawing response within Ullman's model represents an art therapy contribution to the study of dreams. The resulting drawings provide a source of images, feelings, or themes for further exploration in individual and/or group art therapy, or for individual reflection.

Dreams, Psychodynamics, and Art Therapy

The, perhaps, disappointing revelation of unconscious determinism which resulted from the analysis of dreams is made more palatable by the attendant potential for self-awareness inherent in the dreams which are remembered. Their exploration may elucidate the unconscious counterpart of waking concerns and make them available for the dreamer's conscious consideration.

Having played an intimate role in the understanding of psychic functioning, the dream became synonymous with the clinical setting and presence of a professional trained in the workings of the unconscious. With the growing influence of humanistic thinking in the 1960's, a social trend towards greater self-awareness began to emerge. New perspectives supported the reclaiming of dreams and creativity as integral aspects of meaningful functioning. The demonopolization of interpretive skills was advocated so that one's dreams could be used in the service of understanding one's relationship to the social environment (Ullman, 1973).

It is interesting to note that this period of social re-evaluation coincided with the development of art therapy which promotes the inherent healing potential of creative expression. The dream may be considered as the most intrinsic, creative, and spontaneously occuring self-expression. Given that the same characteristics which govern dream formation (i.e. condensation, displacement, symbolization) are also properties of creative expression, art therapy offered another viable means of accessing the unconscious. To apply such an approach to working with dreams suggests itself as a most obvious collaboration.

Tracing the evolution of Freudian, Jungian and existential-humanistic approaches to working with dreams is essential to understanding the influence of the clinical setting on the development of lay interest in dreamwork. Many features of these clinical approaches have been incorporated directly into today's alternative methods. However, much of contemporary dream practice is in direct reaction to the older schools of working with dreams. Principle among these reactions is the rejection of the notion of the therapist as expert without whom the dream's true meaning can not be deciphered.

The suggestion that the dream, rather than the clinician, is the therapeutic agent may have its roots in the recognition that the "many-sidedness of symbolic language" was denied in favour of promoting a particular school of analytic understanding as the "true" one (Fromm, 1951, p. 9). Research has since confirmed that dreams reflect the use of a "private language" (Greenberg & Pearlman, 1993) which is shaped by the idiosyncracies of each dreamer.

When combined with a group model of dream work which accommodates any formal or subjective understanding of symbolic representation, the use of drawing can facilitate each participant's elaboration of the underlying significance of a dream element. A model that also assures the dreamer's control of the process and meaning of the dream supports all participants in their move towards self-understanding.

The following review of the literature will identify the key clinical developments which reshaped therapist-centered dreamwork into a client-centered approach. This trajectory provides a rationale for combining art therapy with a client-focused model of group dreamwork for use with patients diagnosed with an eating disorder.

Freud and the Dream as Object of Analysis

To speak about dreams is to invoke the name of Sigmund Freud and his momentous contribution, The Interpretation of Dreams (1900/1976). Deliberately held back from publication until the turn of this now passing twentieth century, this text has confirmed its place in the modern era with which its author wished to be identified. It became the dividing line between long-standing, disparate notions about mental functioning and a definitive mapping of the relationship between conscious and unconscious processes.

Half a century later, Eugene Aserinsky and Nathaniel Kleitman (1953) identified rapid eye movement (REM) as a distinct feature of the dream cycle during sleep, and so began the revolution in sleep and dream research which would purport to disprove certain tenets of Freud's thesis, notably that the dream is the guardian of sleep (Wolman, 1979). Nonetheless, his conceptualization of manifest and latent levels of dream content as a parallel for conscious thinking and unconscious fantasy continues to inform our understanding of psychic functioning.

The Dream: A Covert Communication

Freud's hypothesis regarding the constituents of the psychic landscape resulted from the study of his patients' dreams and their associations to them. He postulated that in order to avoid disturbing the dreamer with the distress of the dream's true significance, the originating, unconscious meaning was distorted by a series of manouvers which he referred to as the dream-work. The manifest or surface level of the dream was thought to be a disguised version of underlying or latent content which could only be accessed by the patient's associations.

In time, Freud identified several forms of dream-work. These mechanisms of disguise, when applied to the manifest content, revealed the dream's latent

meaning. More than the dream itself, the relationship of the patient's associations to the manifest content became the basis of the dream's interpretation and the discovery of its unconscious, that is to say, conflictual meaning.

Analyst as Expert: Decoding Manifest Resistance

Freud had already encountered his patients' resistances to free association. He understood this as evidence of a separate level of functioning which could override the conscious intention to say whatever came to mind. Resistance proved to be the signpost to unconsicous material bearing on the problem under discussion.

Freud intuited that the conflictual relationship between conscious and unconscious desires also resided within the dream. He likened this tension to that of "the political writer who has disagreeable truths to tell to those in authority", concluding that "he must soften and distort the expression of his opinion" to get his message across (1900/1976, p. 223). In other words, to reach an intended audience without being censored, the writer/dreamer who wants to be heard is advised to exercise self-censorship.

Resistance signals the presence of conflict between unconscious instinctual desires and the conscious need to be acceptable to oneself and others. Impulses of a libidinal nature must, therefore, be denied, sometimes resulting in neurotic or conflictual behavior which represents a compromise between enacting the desire and defending against it. The dream equivalent of this compromise is the censorship carried out by the dream-work.

Instinctual impulses are expressed, and therefore, fulfilled, without being identified as such, by virtue of the distortion which the forbidden wishes undergo. Freud identified several ways in which the dream-work sets about its task of manipulating the unconsious fantasies, notably by way of

condensation, displacement, and symbolic representation. It is less clear whether Freud considered secondary revision another form of dream-work or a more encompassing operation intended to make a convincing narrative of the resulting distortions. Nonetheless, there is no question that Freud's formulation of dream-work supported his hypothesis of dreams as fulfilled wishes in disguise, protecting the dreamer's self-image while allowing sleep to continue undisturbed.

The Unconscious: A Language of its Own

By suggesting that dreams are concerned with unconscious fantasies, and demonstrating that these fantasies are expressed in a language which differs from the waking state, Freud hypothesized that there are two distinct modes of mental functioning. He referred to these as the primary and secondary processes which correspond to unconscious and conscious functioning, respectively.

The significance of this conceptualization cannot be overstated. To have isolated the components of another mode of thinking transformed the idea of an unconscious from mere conjecture into an object of study. The existence of a relationship between primary and secondary processes meant that psychic functioning was a dynamic interplay between the upper and lower levels of Freud's topographic model. It followed that the identification of condensation, displacement, and symbolization had an equal role in the investigation of unconscious fantasies outside of their representation in dreams.

Freud's understanding of a dual mode of thinking was grounded in the formulation of neurosis as a compromised expression of instinctual impulses that cannot be otherwise gratified. Because functioning at the unconscious level was thought to be organized around a preoccupation with infantile

wishes, the analysis of dreams and waking thoughts was dedicated to uncovering this type of content. Freud (1900/1976) was prompted to caution the reader against conducting dream analysis outside of the consulting room, explaining that only a trained analyst could master the particularities of resistance, dream-work, and the reconstruction of unconscious fantasy.

It is clear that in these early days Freud's concept of the analytic process ignored the possibility that the analysand might develop a familiarity with the approach or become fluent enough in his or her symbolic dialect in order to grasp the meaning of his or her dreams without relying solely on the analyst's intervention. His assumptions about the dream's necessary deception of the dreamer promoted the analyst in the role of expert in the interpreting of these subjective events, while downplaying the dreamer's creative potential for self-undersanding.

Dream Analysis: The Foundation of Psychoanalysis

Not only did the interpretation of dreams contribute to the understanding of psychodynamic functioning, but it played an increasingly central role in the psychoanalytic process. As James Strachey pointed out in an essay on Freud (cited in Freud, 1900/ 1976), dream analysis became a useful means of "penetrating the resistances of the neurotic patients" (p. 23).

In elucidating the mechanisms of dream-work and demonstrating the associational thread between conscious thinking and unconscious fantasy, Freud proclaimed that he had discovered "the royal road to a knowledge of the unconsious activities of the mind" (1900/1976, p. 769). His choice of metaphor clearly alluded to the necessity of navigating the distance implied by unconscious determinism. Freud was convinced that the psychoanalyst and his or her analysis of the patient's dreams was the most suitable vehicle for such an undertaking.

As dream analysis became synonymous with the psychoanalyst as expert there were many who could not abide by Freud's hypothesis that in tracing the cause of neurosis, one would invariably be led to the repression of sexual impulses or sexual traumata. They contended that the symbolization of dream-work was little more than a dictionary-like correspondence of assigned meanings for objects and actions which supposedly disguised the underlying wish. Rather than a process of discovery, the analysis of dreams was seen by some as a Procrustean bed in which the dreamer was made to lie with presumed libidinal wishes that left no room for the elaboration of individual, developmental, or current concerns, given that day residue was no more than the trigger which recalled the dreamer's unconscious infantile desires.

Ultimately, Freud's unwillingness to allow for the possibility that other factors may also play a role in the development of neurosis provoked a rupture with the one colleague to whom Freud would have bequeathed the helm of psychoanalysis.

Freud and Jung: Infantile Sexuality vs Individuation

Carl Gustav Jung was among the many who read with interest The Interpretation of Dreams, paying particular attention to the elaboration of repression as it applied to dreams. Jung's own pursuits in the study of word association corroborated Freud's hypothesis of the mechanism of repression. After some deliberation, Jung elected to risk his own credibility within the academic community, rather than publish his findings without reference to Freud, a regular occurrence at the time, given the unpopularity of Freud's hypothesis of neurosis (Jung, 1965). This decision exemplified Jung's courage to stand up for the merits of research, regardless of the implications of the

findings. His relationship with Freud developed out of this willingness to support the pursuit of scientific truth. The relationship between Freud and Jung grew out of their mutual passion for exploring the workings of the mind and the phenomena of neuroses. And it was the passion of their convictions that would lead to their parting of ways.

In contrast to Freud's formulation of neuroses as a compromised response to unconscious instinctual impulses, Jung postulated that psychopathology may represent the psyche's disequilibrium and a striving towards wholeness or individuation, as he called it (Jung, 1967). For Freud, the dream disguised the fulfillment of an unconsious wish of a sexual nature. Jung came to understand dreams as a transmission of the psyche's current state, communicated in a language rooted in the myth-making proclivities of primitive man (Jung, 1967). It is the nature of this symbolic language which contributed, in part, to Freud's contention that the manifest dream was "a "façade" behind which its meaning lies hidden . . . withheld from consciousness" (Jung, 1965, p. 161). Jung thought of dreams as "a part of nature, which harbors no intention to deceive, but expresses something as best it can" (p. 161). As such, dreams can only be conveyed in the naturally symbolizing language of the unconscious which we are obliged to decipher, as best we can.

Jung's ideas about psychic functioning matured along with his growing divergence from Freud's seemingly dogmatic defence of his own hypotheses. As it became increasingly evident for Jung that neurotic conflict was governed by more than sexual repression, he turned to the study of mythology and symbols in search of support for his own hypothesis regarding the spiritual aspect of human experience. By 1911, Jung published the original version of Symbols of Transformation, a text which he well knew

signaled the end of his friendship with Freud and a commitment to exploring his own thinking about the psyche.

Jung and the Dreamer: A Collaborative Exploration

Jung's break with Freud was more than the end of a personal and professional association. With this "sacrifice" (1965, p. 167), as he called it, Jung was prepared to re-evaluate eveything he had learned about working psychoanalytically. He embarked on a different approach with his patients, one in which he "was more concerned to learn from the patient himself where his natural bent would lead him" (1965, p. 120). This shift to a new attitude of exploration within the therapeutic process would impact on Jung's relationship to his patients and their dreams. As Jung later recalled, "the result was that the patients would spontaneously report their dreams and fantasies to me, and I would merely ask, "What occurs to you in connection with that?" or, "How do you mean that, where does that come from, what do you think about it?" The interpretations seemed to follow of their own accord from the patients' replies and associations" (1965. p. 170).

Ever in pursuit of truth, Jung gave up the stance of certainty in favour of engaging with each patient in a collaborative enquiry fueled by mutual curiousity and unknowing. In this way, he was willing to see where they would be led and to what extent his intuitions and observations about psychic transformation would be corroborated. "I avoided all theoretical points of view and simply helped the patients to understand the dream-images by themselves, without application of rules and theories" (1965, p.170).

It would be naive to accept this last statement at face value, as we are well aware that the presumption of avoiding theoretical frames of reference can only be an imagined ideal. Having said that, it would be reasonable to grant that Jung did his best to promote as open a field of reference as anyone in his

position could manage, given a natural desire to test out his own formulations about the psyche.

Amplification

Confident that dreams reflected more than conflicted sexual strivings, Jung had little use for Freud's directory of symbolic correspondences between dream elements and their latent significance which, invariably, turned out to be of a sexualized nature. Jung protested that these were not symbols in the true sense of representing something unique to the dreamer, but, rather, mere signs which stood in place of that to which they were presumed to refer (Jung, 1967). Rather than a disguise, Jung understood the manifest content of the dream as a metaphoric and multidetermined communication, the meaning of which is self-revealing through the exploration of the dream elements.

In the interests of allowing the widest possible field of meaning to suggest itself, Jung directed the dreamer back to the image for associations, rather than associating to the association, as in the approach practiced by Freud. Jung's technique was one of "amplification", of opening up the associated meanings of a dream element so as to explore the nuances of its significance to the dreamer (Jung, 1967). Through this procedure it was demonstrated that a dream can be amplified on three levels, begining with the personal, proceeding to the cultural, and concluding with the archetypal or collective level (Hall, 1991). Most dreams convey subjective and objective levels of meaning, and more infrequently, an archetypal significance.

The insights which resulted from this approach facilitated Jung's conceptualiztion of the dream's compensatory function. The analysis of unconscious conflict revealed the psyche's attempt to integrate a balancing perspective. More importantly for Jung, amplification provided evidence that

dreams address a range of concerns which go beyond those of a sexual nature.

Imaging the Dream

In questioning the nature of the myth which was guiding his life, Jung explored his dreams and and fantasies and was not spared repeated confrontations with his own resistances. Like any analysand, Jung would come "up against a blank wall" (Jung, 1965, p. 175). Recourse to visualization through drawing, working in stone, and eventually, active imagination, provided the necessary triggers to release the seemingly inaccessible material.

Jung understood the effectiveness of this process as the result of giving visual form to the feelings which embody the resistance. "To the extent that I managed to translate the emotions into images - that is to say, to find the images which were concealed in the emotions - I was inwardly calmed and reassured" (Jung, 1965, p. 177). Jung, therefore, encouraged his patients to engage pictorially with their dream images, having himself experienced the benefits of giving material form to his inner experience.

Jung recognized that objectifying the dream or fantasy image through painting, drawing, or sculpting was a way to give form to feelings that could not otherwise be articulated. In this manner, resistance is addressed by producing the equivalent of a modern day polaroid snapshot of an inner image to which only the photographer/dreamer has access, but for which the meaning in not apparent, and therefore, can not be put into words. When a dream's feeling content is vague, and it is not visually mapped out or objectified, its meaning remains submerged within the manifest expression of the dream, as the polaroid image remains latent within the film's emulsion.

Jung's identification of the intimate relationship between the image and the affect contained within points to the conflictual, yes/no, good/bad core of resistance. Furthermore, the observation that this act of creative expression produces a feeling of calming reassurance speaks directly to the inherent healing capacity of image-making which was to become the foundation of art therapy. Jung discovered that visually mediating those psychic events which resist verbal articulation can bridge the primary inner process with the higher functioning secondary process, rendering manifest that which seems to exist beyond description.

Jung (1967) demonstrated that the image-making process itself is the language of the unconscious. Beyond the pictorialization of dream elements or fantasies, the creation of a spontaneous image can equally reveal one's psychic state. Jung came to understand this through his use of mandalas, or drawings within a circle. He gradually recognized that within the mandala can be observed the psyche's daily movement towards individuation which he came to think of as "the circumambulation of the self" (Jung, 1965, p. 196).

Symbolic Representation: A Personal and Social Language

It is this image-based depiction of experience which gave birth to our myths, the first attempts to soothe existential anxiety by assigning meaning to the big events beyond the control of our collective lives. It continues to be a language through which we can create some understanding of the unpredictable aspects of our relationship to one another and to ourselves.

In attempting to reconcile Freud and Jung's differing ideas about the meaning of dreams, Erich Fromm (1951) suggests the inclusion of a middle ground which bridges the seemingly incompatible. He proposes that dreams express not only irrational, childish wishes, but wishes related to the anticipated attainment of valuable goals. Likewise, the unconscious,

transcendent wisdom of dreams may be alternately expressed as the individual's insightful awareness and problem-solving abilities related to waking concerns. Fromm credits dreams with reflecting not only "the lowest and most irrational", but also "the highest and most valuable functions of our minds" (p. 47).

Given this range of possibilities, he stresses that a correct interpretation requires artful elucidation through attention to the dreamer's life context and associations without, a priori, submitting the dream to a particular school of analytic thought. Furthermore, he expresses the conviction that effective understanding of dreams should not be limited to the context of psychiatric treatment of neurosis. Fromm states unequivocally that the dreamer schooled in the symbolic language of myths and dreams is best equipped to understand not only his or her own personality, but "a level of experience that is specifically human because it is that level which is common to all" (p. 10).

This last quotation reminds us that the dreamer lives and dreams within a social context, suggesting that responsibility for oneself is incomplete if it does not take others into consideration. In looking back to make sense of the schism between Freud and Jung's conceptualization of dreams, Fromm seems to have anticipated, perhaps unknowingly, the emerging influences of phenomenology, existentialism, and humanism on the interpretation of dreams.

Later Developments: Existential Humanistic Psychology

The Influence of Phenomenology

Existential-phenomenological psychology developed out of the application of a phenomenological approach to human experience. Originating in the European existentialist movement based on the work of philosopher, Edmund

Husserl, phenomenology concerns itself with the "science of phenomena, that is, of objects as they are experienced or present themselves in our consciousness" (Misiak & Sexton, 1973). This "return to the things themselves" (Husserl, cited in Craig, 1990, p. 69) was intended to elucidate the underlying structures specific to each experience which may have become obscured by surface appearances or layers of assumptions generated by habitual ways of thinking, responding, and experiencing.

This conceptualization appealed especially to existential philosophers and psychiatrists interested in comprehending human existence as it reveals itself discretely in direct experience. Phenomenology also extends to the search for understanding of the dream's meaningfulness in relationship to waking life. Psychotherapists who use an existential-phenomenological approach to dreams maintain that it contributes to a developing capacity for a more fully authentic existence (Craig, 1990).

The primary assumption is that the same limitations of a person's existence that are seen in waking life are also seen in that person's dreams (Boss, 1958). By becoming aware of such limitations, the ego can choose to be more open to possibilities that are outside of its usual view of itself and its world. In exploring the question of the dream's meaningfulness, Craig (1990) suggests that the dreamer is open to three types of existential possibilities. The first reflects those aspects of life which are already consciously acknowledged and for which the dream presents new options for consideration. The second bears on those possibilities which are ignored despite awareness of them. The dream offers an opportunity to reconsider these choices and their potential to enhance waking experience. The third type of content touches on those aspects of our lives of which we are unaware. The dream enables an integration of these unknown elements, thereby promoting growth and

development. Craig emphasizes that "it is while dreaming that an individual may first dare, albeit timidly, to actualize some of his or her own authentic possibilities for being human" (p. 77).

It seems reasonable to suggest a parallel between Jung's concept of the dream's compensatory function and the existentialist emphasis on the dream's presentation of new options or unexplored possibilities. In addition, the concept of individuation could be likened to the notion of actualizing one's authenticity. The goal of dream interpretation in both these approaches is to elaborate the dreamer's experience of the dream elements without the imposition of preconceived notions. The comparison, however, stops short of the third or archetypal level of meaning which Jung maintained was present in some dreams. Medard Boss made this clear to James Hall during a 1968 conversation in which Boss underlined the importance of eschewing "any prior theoretical category on the immediate experience of the dream" (Hall, 1991, p.56). In practice this poses the problem of giving up any conscious consideration of the paradigms which order one's experience.

Perhaps it is for this reason that one presentation of an existential model for the understanding and interpretation of dreams begins by delineating what the dream "is not" (i.e. "not a symbolic disguise . . . not wishful distortions of impulses and strivings") (Moustakas, 1989, unpublished manuscript, p. 2). In this conceptualization the relationship between the dreamer and the dream is understood as reciprocal and represents a union of mutually influencing elements consisting of Being and World such that each individual is a unique work in progress evolving in response to, while influencing, one's on-going dreams. The dream's meaning results from an analysis of what is revealed in the relationship between the dreamer and the dream elements. This understanding is then extended to waking life as a

question about the potential relevance of this meaning to the awake dreamer (Boss, 1982). Consistent with other schools of psychology, existential-humanistic psychotherapists refer to the dream as a guide to the individual's development within the therapeutic process (Craig, 1990).

Humanistic Psychology

The evolution of humanistic psychology represents the assimilation of phenomenological and existential thinking and the contributions of many individuals, but it is the work and person of Abraham Maslow (1968, 1970) which is most readily identified as the central figure in its development. His articulation of a psychology of being developed out of Kurt Goldstein's concept of self-actualization and emphasized the potential for positive growth (Misiak & Sexton, 1973).

Maslow (1971) maintained that the failure to unfold one's potential may result in neurosis, echoing Jung's understanding of psychic dysfunction as a call to individuation. He thought of humanistic psychology as a structure which encompasses all other theories of psychology, suggesting a study of the entirety of human experience, from creativity and growth, to the fulfillment of potential.

The recognition that "a complete description of what it means to be alive as a human being (is a goal which is not) likely ever to be fully attained" (Bugental, 1967, cited in Misiak & Sexton, 1973, p. 117), may explain why there is no approach to working with dreams which is specific to humanistic psychology. Hall (1991) concludes that the emphasis on the dream's healing and creative functions in the absence of an elaboration of the nature of conflict makes humanistic psychology a counterpoint to "the other pole of the pessimism found in early Freudian writing, expressed particularly in the concept of the id" (p. 55).

The dream's initial identification with neurosis and the indirect expression of infantile sexuality was challenged by Jung's contention that the manifest content is a symbolic representation of the psyche's evolution towards balance and wholeness. As such, libido is linked to the notion of a life force in which sexuality, creative expression and self-development are equally compelling preoccupations. Consequently, dreams are thought to address the multiplicity of human experience, with or without conflict, as it unfolds daily.

The influence of phenomenology brings to the interpretation of dreams a renewed emphasis on the subjectivity of meaning and reinforces the uniqueness of each dreamer's visual language. Humanistic thinking reminds the individual that a meaningful existence can be limited by one's capacity to imagine and strive for the best in oneself. A century after the publication of Freud's unprecedented contribution, dreams are still linked to the therapeutic process, but also have relevance outside the therapy room as a legitimate means of developing the dreamer's self-awareness and sensitivity to the larger contexts of life.

Dreams and the Public: A Non-Clinical Appreciation of Dreams

The growth of existential-humanistic psychology was part of a greater global post-war shift in the direction of a more holistic perspective on psychic functioning which took into consideration subjective phenomena. This shift applied "not only to all the sciences but also to the humanities and to contemporary thought in general" (Sperry, 1987, cited in Hillman, 1990, p. 14), resulting in a surge of curiosity about dreams as one variety of inner experience which may hold meaning for the individual's waking life.

The human potential movement provided a backdrop against which a variety of other influences converged. Hillman (1990) lists the growing

popularity of spiritual and metaphysical organizations, feminist consciousness raising groups, and exposure to dream analysis within a therapeutic process as sources of impetus to the development of what came to be known as the "dreamwork movement" in 1982-83 (p. 14). It seems reasonable to conclude that the launch of the Dream Network Journal in 1982 and the Association for the Study of Dreams (ASD) in 1983 responded to this growing interest while, simultaneously, contributing to it.

A more extreme version of the search for expanded consciousness was promoted by authors interested in developing conscious control of dreams, otherwise known as lucidity. Although lucid dreams are a naturally occuring event which, indeed, can be increased through active effort (LaBerge, 1985), the desirability of this sort of impingement on spontaneously emerging intrapsychic phenomena continues to be the subject of debate within the professional dream community (Eighth Annual Conference of the Association for the Study of Dreams, Chicago, 1990).

The ASD became a forum for the convergence of professionals (i.e. clinicians, researchers, academicians) and those without clinical training, but with an active interest in working with, studying, sharing or applying dreams. The growing number of self-styled dreamworkers was evidence of the call to demonopolize interpretive skills (Ullman, 1973) in conjunction with the notion of "deprofessionalizing the dream" (Ullman, 1982). Among them were established researchers and clinicians, trained in Freudian or Jungian analysis, who were dissatisfied with the limitations of these schools. Looking to dreams as the most direct means of expanding consciousness, they responded to the public's eagerness to learn how to understand their dreams (e.g. Faraday, 1972, 1974; Garfield, 1974). Of significance was the self-

appointed mandate to help the lay reader demystify dreams as messages which could ony be comprehended by a trained professional.

Ironically, the deprofessionalization of the dream was facilitated, at least in part, by professionals, some of whom contributed to the re-evaluation of the clinician's authority in the form of research data. As of the 1950's, various theories about the function and meaning of dreams began to emerge subsequent to the identification of rapid eye movement (REM) and its relationship to dreaming. Increasingly, the dream's structure and metaphoric language was recognized as being, not obscure, but uniquely suited to conveying, with specificity, the salient elements pertinent to the dreamer's current life experience. Developments in psychoanalytic thinking brought a hitherto unknown legitimacy to use of the manifest dream content as a locus of meaningful reflection on the state of the ego.

Models of Dreamwork: Dreamer-centered Guidance

With the advent of the dreamwork movement, dreamers could now learn how to work with their dreams experientially, that is by participation in a dream group, or by working individually with an experienced counselor or dreamworker, or by the more traditionally academic form of reading the literature on the subject, as is discussed below. The group format provided an unstructured forum for study and discussion or made use of one or more models for working with dreams. A group could also alternate between these two approaches, depending on the interests of the members and the nature of the leadership (Hillman, 1990). Whether the group rotated leadership or functioned without a leader, the general purpose was to learn about oneself through the understanding of one's dreams.

This movement was greatly facilitated by publications which instruct the reader in various forms of dream work, sometimes with examples from the

authors' own dreams and work with dreamers. One very popular method, called "dream interviewing", was based on the premise that the dreamer is the producer of the dream and, therefore, best placed to know its meaning. It was described as a "direct approach that does not require a therapist or detailed knowledge of any particular dream theory" (Delaney, 1979, p. xviii).

Some texts were addressed to clinicians and dreamers who prefer to work on dreams independently or with a partner (e.g. Hall, 1991). While most books describe a method for working alone or with others (Garfield, 1974; Delaney, 1979), some adapted the approach so that it can be used in any format, including groups (Bosnak, 1986).

In a more recent publication (Mahrer, 1989), guidelines for an experiential approach to working with dreams cautioned against dreams in which there are not at least two peak episodes of feeling. It was thought that the presence of more than one feeling allows for the identification of a common factor or theme, but more importantly, it is thought that dreams with only one such passage may be recurrent dreams which call for the attention of a clinician. This is a rare instance of identifying dream material which may be deemed unsuitable for exploration outside a clinical context. A more representative view (Ullman & Zimmerman, 1979) suggests that the only danger in working with dreams is a lack of respect for the dreamer's right to be safe from the imposition of meaning. Furthermore, if it is agreed that "by becoming more known to ourselves we are stronger, not weaker, [then] [i]t is not dangerous to work with dreams. It may be dangerous not to do so" (p. 32).

The Dream in Current Psychodynamic Practice

As alluded to above, the dream's importance within the psychoanalytic process had been relativized somewhat by developments stemming out of ego psychology (Greenson, 1970/1992). In addition, the evolution of self psychology and the growing influence of object relations theory also seem to have contributed to the dream's declining importance (Mahrer, 1990). By contrast, the dream in Jungian analysis continues to maintain its original relevance, while the importance of dream work in the more recently developed approaches, such as Gestalt or experiential therapy, reflects an emphasis on the implicit relationship between understanding dreams and psychic well-being (Mahrer, 1990).

In contrast to the perception that practitioners working with dreams in psychotherapy (i. e. psychiatrists, psychologists, social workers) represent no more than 15 to 20 percent of the total (Mahrer, 1990), a recent survey (Keller et al, 1995) reports that 83% of responding clinicians in private practice worked "at least *occasionally*" with their patients' dreams, with predominant use of a Freudian or Gestalt approach (p. 1289). Neither of these make reference to work with dreams in group psychotherapy.

The significance of either report remains, however, questionable. The former (Mahrer, 1990) appears to be a subjective "impression" estimated by the author, while in the latter (Keller et al,, 1995), there are no numeric values for the designated categories "occasionally", "moderately", "frequently", and "almost always" (p. 1289). If the percentage of those who "occasionally" work with dreams is substracted, the respondants with an 'at least moderate' frequency drops to 30%. Although this reflects a closer

correspondence to the first informal report, a more thorough survey would be necessary before any definitive conclusions could be drawn regarding the current frequency of work with dreams in psychotherapy.

The fact that "many respondents" (p. 1289) (again, no exact numbers) reported working with dreams only in response to their patients' initiative would seem to suggest a lessening interest in focusing on the dream as an integral component of the therapeutic process. Concluding that this, in turn, leads to a diminishing attention to teaching and training on the subject (Hall, 1991) may seem dramatic. However, if one considers that Keller et al. (1995) report "personal initiative rather than didactic instruction" (p. 1289-1290) as the major source of experience in working with dreams, there may well be reason to question the status of dream analysis in clinical training. In either case, it reflects the truism "that those therapists who value dreams will tend to use them a great deal, while those who see little value in dreams use them sparingly if at all" (Mahrer, 1990, p. 43).

The Dream in Individual Analysis.

Psychoanalysis situated the interpretation of dreams squarely in the hands of professionals who were versed in the workings of resistance, repression of sexual and aggressive impulses, and the process of free association as a means of identifying the patient's conflictual strivings. This method reflected and extended to the hypothesized duplicity of dreams as distortions of instinctual desires in conflict with what came to be known as the conscious ego. This deception necessitated an undoing of the dream-work which generated the manifest level as a disguise for unconscious fantasies. Given these parameters, working with dreams was seen as a serious undertaking which was best addressed in the analytic consulting room (Freud, 1900/1976). Thus,

the interpretation of dreams became the sole domain of the professional who, through training in psychoanalysis had developed an expertise.

Jung's divergent conceptualization of the meaning of dreams relied on the analyst's ability to distinguish and help elaborate its subjective and objective levels of meaning. Of even greater necessity in his approach was the analyst's knowledge of myths and facility with symbols in order to amplify the third or archetypal level of the dream (Jung, 1967).

Although Jung's emphasis on the dream's sincerity as an intrapsychic communication presented the dream as more accessible to the dreamer compared to Freud's understanding, it remained that the task of dream interpretation could not be satisfactorily complete without the participation of an expert. This meant that the understanding of dreams was best addressed in a professional, clinical context.

Initially an integral component of the analytic process, dream interpretation eventually lost its particular status as the "royal road" (Blum, 1976). This was understood by some as a reflection of the growing interest in ego psychology (Spanjaard, 1969). By the seventies, a shifting consensus in the psychoanalytic community weighted dreams on a par with other psychic material (Waldhorn, 1967). An extreme view is expressed by the suggestion that "any competent therapist should be able to carry forward analysis without the use of dreams at all" (Hall, 1991, p.245).

The dream had been subsumed into the so-called greater therapeutic process to the point that, in today's practice, the dream is often used to inform the analyst of how to proceed with the analysis, rather than being explored for what it has to offer in and of itself. It is no longer considered "as a special communication but as an aspect of the communicative totality of the session's context" (Plata-Mujica, 1976, p. 336). Others argued that exploration of the

unconscious must include the dream as it represents an intersystemic interaction (i.e. id, ego, and superego) resulting in communication which differs qualitatively from what can be produced during waking consciousness (Altman, 1969).

Despite the shift in attention to dreams within clinical practice, the intervening years have witnessed a wealth of observations leading to theoretical formulations based on clinical studies regarding the dream in relation to specific psychopathological states, such as in schizophrenia (Wolman, 1979), the depressive personality (Bonime, 1993) or in dissociative states (Marmer, 1993).

The Dream in Group Analysis

Joseph Henry Pratt, a Boston internist, is credited with having organized the first therapy group in 1905 as a way of addressing the needs of patients with advanced tuberculosis who could not afford in-patient treatment (Shaffer & Galinsky, 1989). A variety of group models was subsequently applied to a range of patient populations, but it was the growing number of soldiers during World Was II requiring psychiatric attention that stimulated the use of group therapy as an expediant means of treatment (Yalom, 1985).

The practice of group psychotherapy evolved along two conceptual lines. Differences in the understanding of the individual's relationship to the group and the group leader stemmed from an orientation to group work as an extention of the analytic dyad (i. e. individual treatment in a group context) (Slavson, 1950). Some clinicians concluded from their observations on group dynamics that psychoanalytic concepts could be applied to the group-as-a-whole rather than the individual patients (Foulkes & Anthony, 1957; Bion, 1961), although more current applications of the latter perspective also consider the individual's contribution to the group process (Debanne, 1994).

Despite differences, there seems to be a consensus that, not unlike individual therapy, it is the therapist's response to the introduction of dreams that will determine the quantity and types of dreams which are presented within the group (Yalom, 1985). If the presence of the group does not inhibit sharing of a dream altogether, let alone the the member's free associations, other determining factors include the particular characteristics of group members, as well as the particular phase of group work (Natterson, 1993).

In contrast to individual psychotherapy, it is thought that the importance of a dream presented in a group must be deliberated in terms of its bearing on group dynamics versus its significance to the personal context of the dreamer (Natterson, 1993). To this end an effort must be made to identify those apects of the dream which bear on the group and those which are specific to the individual's functioning within the group. Ezriel (1980) gives the following example.

> In my interpretation (of a female patient's anxiety dream recounted in group psychoanalytic therapy) I referred to this accident only as representing in symbolic terms a wish to destroy a couple in intercourse, namely, myself and a female patient who she thought was flirting with me. All the other details of the dream, the particular content of which did not seem to have a direct bearing on the group situation, were remarked upon as an attempt to seduce me into a private relationship with her to the exclusion of the rest of the group and especially of the other female patient. The essence of her recounting the dream in all its details seemed to be part of her reaction to a jealousy-arousing situation in that particular session when she felt that another female patient got on too well with me. (p. 135)

This example illustrates the "expert" factor at work, whereas there is much reporting in the literature that, beyond the therapist's response to the initial presentation of dreams, of great importance is the manner in which the dream is permitted to be received by the group members. Members' associations and projections can lead to understanding, and sometimes an interpretation offered by a member may be more readily received compared to one offered by the therapist.

Dreams and Art Therapy: Drawing on the Unconscious

The identification of the relationship between primary and secondary processes is the cornerstone of psychotherapy. The dynamic nature of the psyche makes its observation a method for addressing feelings, thoughts, and behaviors which are at odds with conscious intentions. The underlying tensions are revealed not only in dreams or images arising from an assortment of deliberate verbalized thoughts, inadvertent slips, or idle daydreams. They may be equally observed in a collage, doodle or three-dimensional object. Each of these naturally occuring forms of expression (dream, word, image) lends itself as a medium through which the work of psychotherapy can be undertaken. However, these forms provide access to deeper layers of meaning precisely because they are part of everyday life. Some authors have suggested that everyone can and should learn to speak the "forgotten language" (Fromm, 1951).

As we have seen, working with dreams is synonymous with the study of the unconscious. The visual depiction of dreams has proven to be a natural means of accessing and enlarging this exploration. Furthermore, because the primary process in which the unconscious functions, and out of which dreams are formed, is equally at play in the creation of spontaneous two- and

three-dimensional images, some clinicians even consider the image produced in art therapy as the "manifest art", thereby placing the emphasis on "its analogous relationship to the manifest dream" (Vaccaro, 1973, p. 82).

The evolution of image-making as a therapeutic modality stems from the inherently healing qualities of creative expression (Kramer, 1958). To engage in a process of image-making, rather than the analysis of a dream, can be as effective a means of externalizing the underlying dynamics at the root of psychopathology. This view is supported by observations that patients naturally gravitate towards representations of unconscious conflicts when given the opportunity for spontaneous expression (Naumburg, 1953, cited in Ulman, 1986; Vaccaro, 1973; Landgarten, 1975; Meyerhoff, 1977). If we consider that pictorial representations escape censorship more readily than verbalization (Ulman, 1986), it seems obvious that to render a dream into images enhances access to the nature of the conflict and enriches the intrapsychic dialogue.

While it is apparent that art therapy owes it's credibility to what dreams have taught us about primary and secondary processing, the emphasis in the literature is clearly on working with spontaneous or directed image-making, rather than with images from dreams. Perhaps it is precisely the fact that image-making in itself facilitates the depiction of conflict which accounts for the paucity of reference to work with dreams in the literature on art therapy.

Interestingly, there is evidence that dream analysis does inform the way in which at least some art therapists consciously conceptualize their approach to working with their patients' spontaneous or directed images. Meyerhoff (1977) proposes the idea of a screen in referring to two- and three-dimensional images as outward projections, in comparison to dreams which "may be looked on as a series of inner pictures" (p. 135). Given this

formulation, the author responds to the images of her child and adult patients in the form of a dream interpretation.

Citing both Freud's acknowledgment that the unconscious communicates via images and Jung's use of art in his analysis of patients, Landgarten (1975) asserts that "everyone projects images on an inner screen" (p. 65). The author extends this metaphor for primary process in nocturnal dreams and daydreams to the creation of spontaneous image-making, suggesting that the images produced within art therapy sessions ought to be approached in the same way as dreams.

Of interest in the work of these two art therapists is the contrast in the way each one describes the task of interpretation. Landgarten (1975) understands the therapist's role as one of helping to "bridge the gap between non-verbal expression and verbal communication" (p. 65) using whatever symbolic perspective seems appropriate, adding that "of crucial importance is the art therapist's respect for the client's interpretation" (p. 65). Meyerhoff (1976) describes a more directive stance in which she initiates her patient into a Jungian perspective on dreams which emphasizes a reading of dream characters on both a subjective and objective level. Despite these differences, the results converge in the patients' development of insight into their unconscious conflicts.

Dreams in Individual and Group Art Therapy

When dreams are reported in the art therapy literature they often appear as spontaneous emergences in an on-going, non-directive process, as they would be in verbal psychotherapy. However, dreams are also elicited by the art therapist as a means of initiating the therapeutic process. For example, consistent with analytic thinking (Hall, 1991), Landgarten (1975) maintains that dreams which occur at the start of therapy can provide the patient (and

therapist) with insight as to unconscious feelings regarding the therapy. She describes a dream drawing by a woman beginning art therapy, but does not indicate whether this came about spontaneously or as a result of the therapist's suggestion.

Meyerhoff (1976) describes her first contact with an eager-to-please young woman who "slips through my fingers like a wet fish" (p. 88). Frustrated by her patient's inability to respond in a direct manner, the art therapist finally asks her patient about her dreams. The patient recounts two dreams and the therapist immediately grasps this woman's preoccupation with what others think of her, hence her reticence to commit to a point of view. Of note is the absence of reference to any image-making in this first hour.

When a dream is presented in the second hour, Meyerhoff (1976) "explain(s)" to the woman the dream's meaning, using Jung's conceptualization of objective and subjective levels of dream characters. Meyerhoff decides against exploring the patient's repressed anger when she observes the patient's tentative response to a situation which is clearly disturbing. It is only in the third hour, after the recounting of a dream which seems to express the patient's repressed sadness, that the patient is asked "to try and paint her sadness and, if possible, her anger" (p. 89). The patient arrives at her fourth session with four images, none of which convey the vagueness of her verbal expression. Not surprisingly, she is "dismayed at the aggression and fierce anger coming out of her" (p. 89). This confrontation with the visual depiction of the affect expressed in her dreams signals the recognition of conflict which can no longer be denied.

As the therapy evolves, the patient continues to bring in images executed outside of the therapy sessions, but based on the material discussed. Some

images are spontaneous, while others result from themes suggested by the art therapist. Dreams continue to be reported, although only certain ones are visually depicted. The dreams often appear as part of a series, reflecting the young woman's evolution within the therapeutic process and her emerging readiness to deal with issues which she has long avoided.

We see from these examples that dreams in individual art therapy can facilitate the beginning phase of treatment by providing a focus for the patient and a means for the art therapist to assess the individual's core conflict. It is also clear that intermittent dreams can serve the therapeutic process as they would in verbal therapy, as signposts of the progressive shifts in the evolving treatment. However, unlike the dyadic exchange which leads to a verbal interpretation, only the patient engages in the visual rendering of a dream. Perhaps as a consequence, the resulting image seems to more convincingly impress upon the patient the nature of the conflictual dilemma. Jung would sometimes paint an image from his dreams ". . . in order to impress it upon my memory" (1965, p. 183).

Meyerhoff's (1977) paper, entitled Art as Therapy in a Group Setting, is an example of how the group setting is sometimes no more than a way for numerous individuals to work concurrently, each one focused on his or her own issues. In this paper, the work of two children (in two different groups) is described as if it transpired within a dyadic, rather than a group, context. There is no description of the structure of the group, number of participants, etc., and no reference to either child's interactions with others in the group.

The first of the two cases presented in this paper describes an eleven year old girl who eventually consented to begin treatment with a psychologist to whom she recounted a dream. The balance of the material is based on her paintings in group art therapy, but no other dreams are included, nor was the

first dream rendered pictorially. As in the above example from Landgarten (1975), there is no specification of whether the dream was solicited or recounted spontaneously.

One must conclude that the author's purpose in including the dream was to portray the child's preoccupations at the time, as well as to demonstrate that these issues were spontaneously addressed through the child's subsequent visual responses to topics assigned in the group. This supports the claim that image-making can facilitate the working through of unconscious conflicts in a manner similar to dreams.

A Dreamer-Centered Model: The Healing Function of Group Work

The evolution of dream work beyond the confines of the clinical setting took place in tandem with reseach developments which pointed to the manifest dream as a ". . . direct, metaphorical, or symbolic representation of ongoing problems or dilemmas in the dreamer's life . . . (which) are directly understandable given the dreamer's self-experienced dilemmas" (Schwartz, 1990, p. 54). In concert with these findings, Montague Ullman was formulating his own perspective on the function and meaning of dreams (e.g. 1956; 1958a; 1958b; 1958c; 1960; 1973). He was determined to find an effective means of teaching clinicians about dream work, and eventually identified a set of skills which he organized into an experiential model for learning to work with dreams. The success of this approach led him to consider the viability of passing on these skills to any dreamer interested in exploring the creative reflections intrinsic in dreams (Ullman & Zimmerman, 1979; Ullman, 1979; 1984; 1987; 1988; 1990). Not surprisingly, he stands out as one of the professionals who is credited with actively facilitating the public's growing desire to work with dreams outside the clinical setting (Hillman, 1990).

Ullman's efforts led to the formulation of an experiential "group approach to dream work oriented to connecting the dreamer to the dream in a way that is different from the way dreams are used in a formal therapeutic situation" (Ullman, 1988, p. 1).

Ullman's conceptualization of the dream was rooted in experimental sleep and dream reseach which dates back to the 1950's. His formulation of the vigilance theory (1958) is one of many others which evolved, such as the notion that the dream serves a sentinel function (Snyder, 1966), an information processing (Palumbo, 1978), and a learning function (Greenberg & Pearlman, 1974), In trying to come to terms with Freud's hypothesis of wish fulfillment, these studies helped Ullman to conclude "that dreaming is a naturally recurring period of partial arousal during sleep, which occurs when our brain is awake enough to give us the opportunity to react to any tension arising out of our recent life experience" (Ullman & Zimmerman, 1979, p. 31). These tensions refer specifically to those which once menaced our physical lives in the natural environment and which today represent the events that disturb our sense of well being within our social environment. This perspective maintains that regardless of content, the dream includes an emotional climate which is the locus of the tension seeking to be addressed, the elaboration of which is essential to understanding the dream.

Not unlike the Jungian or existential humanistic perspective, the dream in Ullman's view is endowed with an intrinsic honesty which confronts the dreamer with aspects of experience which may be ignored while awake. The notion of deception extends only to that in which we ourselves engage. The dream boldly confronts us with our own deceits and unacknowledged hesitations, and it is the integration of this confrontation which has the potential for healing (Ullman & Zimmerman, 1979).

Ullman's conceptualization of the vigilence theory mentioned above is the basis for his conviction that to share one's dreams is to address the unperceived tensions and distortions which are part of the dreamer's experience of and contribution to a less than optimal social environment. Dream work in a group context acknowledges the social sphere as the underlying basis of the experiential events which are the dream. These events represent the individual dreamer's attempts to work through the, as yet, unidentified tensions. With the group's help, related thoughts and feelings not normally available to the dreamer are brought to bear on a current life situation. Ullman (1984) maintains that "(e)motional healing, in contrast to physiological healing, takes place outside of the skin or physically defined limits of the person" (p. 128). Therefore, the healing action of the dream is consolidated in the interpersonal field in which the dream work takes place.

Despite the well thought-out formulations and scientific research, Ullman acknowledges that his approach is but one of many in a field still in the early stages of exploration. What seems useful from a clinician's and dreamer's point of view is his integration of psychoanalytic theories that include Freud's notion of the release of instinctual impulses, as well as the importance of the compensatory function of dreams as elaborated by Jung (Ullman & Limmer, 1988). More importantly, perhaps, is the mandate to pursue the essence of what has been identified as the "creative metaphor" (Briggs, unpublished manuscript, cited in Ullman, 1984), the understanding of which "enhance(s) the vision we have of ourselves and the universe" (p. 122). It is precisely the nature of this pursuit which links the conceptual basis of Ullman's approach to dream work with art therapy.

Safety and Discovery: Essential Factors in Group Dream Work

Ullman (1984) identifies three features of the dreaming experience that contribute to its capacity to provide healing in our waking lives. These features include the dream's relevance to on-going issues, the mobilization of relevant information from the past, and the dream's ability to bring us closer to the truth of our waking lives. The dream accomplishes this through uniquely expressive metaphors specific to the issues at hand (Ullman, 1979; 1988) For Ullman, the dream work is the process of elaborating these metaphors in light of the dreamer's present life situation so as to create meaningful representations of pre-conscious concerns.

In order to facilitate this work, there are two fundamental dimensions underlying Ullman's model of group dream work. The first, known as the "safety factor", is the non-negotiability of the dreamer's need to be in control of the process, and the second, referred to as the "discovery factor", is the dreamer's need to learn something from the dream as a consequence of engaging with it (Ullman & Zimmerman, 1979).

The safety factor is what makes it possible for a dreamer to consider sharing a dream with others, given what Ullman calls the "double jeopardy" (1988, p. 4) of making oneself vulnerable through the exposure of a most personal experience. One is exposed not only to the unpredictable responses of others, but also to the unknown meaning of the dream. To share a dream in a group may be the equivalent of risking the depths of an unknown pool in the presence of unproven lifeguards. The dreamer's safety is assured by the right to say as much or as little as is desired, or even to bring the process to a halt without having to explain. The second most important goal in this model is the dreamer's need to understand the significance of the intrapsychic

communication which has suceeded in leaving its trace on the waking ego (Ullman, 1988).

One of the advantages of a group approach is the presence of others who are available to reflect on the dream and to share their own thoughts and feelings, some of which may have a direct bearing on what the dreamer has yet to become aware of. The volume of associations and amplifications, as well as the dreamer's natural resistance to knowing, can make the discovery of appropriate links to the dream a creative process in its own right. The one reliable indicator is "a feeling of fit" or an implicit understanding and recognition on the part of the dreamer (Ullman, 1984, p. 123), not unlike the phenomenon of "felt change" identified by Eugene Gendlin (1978). The ultimate confirmation of this fit is nothing less than the feeling of having discovered something which opens new insights into the dream (Ullman & Zimmerman, 1979). It is unlikely that without the guarantee of safety and control over the process, the dreamer could be open to the discovery of unconsidered possibilities.

An Integration of Dreams, Drawing, and Therapeutic Consolidation

People are alone while asleep and the only witnesses to their dreams, yet, paradoxically, waking life is a series of experiences with others, as is often reflected in dreams. The notion of having help to understand a dream exploits the assumption that the commonality of life experience can suggest relevant meanings against which the dreamer may be defended, but which are close to consciousness by virtue of the dream being remembered and the dreamer being willing to share it.

This approach to working with dreams differs from a group format in art therapy in which each member works on his or her own dream. It also

differs from the treatment of a dream shared in the context of a verbal psychotherapy group. Depending on the therapist's orientation, his or her goal may be to address those aspects of the dream most relevant to group issues before touching (if at all) on the aspects which relate specifically to the individual (Ezriel, 1980). In another approach, the therapist may invite group members to share their associations and then interpret these in relation to the current state of the group (Yalom, 1985). Again, this may exclude the dreamer's elaboration of more personal reflections. While members' projections also figure in Ullman's model, their purpose is to elicit meaning which is personally relevant to the dreamer. This is accomplished through the members' willingness to identify with the selected dream as if it was their own. In so doing, each member unavoidably calls on his or her own experience as a point of reference. Therefore, these projections can be revealing to both the dreamer and the group member.

From an art therapy perspective, Ullman's model, despite its origins, appears to have some application in a clinical setting, as a bridge for the individual's return to the community. For reasons elaborated in the review of the literature that follows, patients diagnosed with an eating disorder are identified as potentially benefitting from this type of intervention.

The totality of Ullman's work demonstrates that dreams are a path to self-knowledge and a way to address our connections to others. Introducing this approach towards the end of treatment can suggest to patients a means through which to consolidate their gains while developing their creativity. When coupled with a drawing response to the shared dream, this approach offers everyone the opportunity for self-exploration in that the drawing may also reflect issues closely linked to the maker of that image.

Engagement in this process asks each member to exercise his or her capacity to focus on someone else's preoccupations in exchange for a similar investment at another time. In return, this creative participation obliges members to make use of their own dreams, fantasies, and preoccupations. The extent of concurrence that may be present in a group of individuals being treated for related issues opens up the associational pool and increases the dreamer's potential for self-understanding.

Peer membership and the opportunity to contribute to a shared pursuit of self-knowledge reinforce the notion of healthful engagement with others, in contrast to the perpetuation of identification with symptomatology and impaired functioning. An intervention which can accommodate a shift in one's frame of self-reference can support the sometimes difficult transition from treatment to discharge.

Culture and Symptomatology

The perception of anorexia nervosa as the "new" or "modern" disease of the 1970's resulted from the steady increase in clinical presentations during the preceeding 15 to 20 years (Bruch, 1978). This was attributed to the growing impact of fashion trends created and promoted by the media and directed specifically at impressionable adolescents and young adults in our culture. Yet this illness is not without historical antecedents. There is written evidence that women throughout the Middle Ages were observed to engage in self-imposed food restriction or fasting (Gordon, 1990), and they continue to represent the majority of diagnoses (Abraham & Llewellyn, 1992).

Some authors insist, however, that we distinguish between medieval asceticism, in which food deprivation is a form of spiritual practice deserving of the title ". . . anorexia mirabilis (miraculously inspired loss of appetite)" (Brumberg, 1988, p. 42), in contrast to the contemporary phenomenon of self-starvation known as anorexia nervosa. Even having made this distinction, the "lack of appetite" which *anorexia* signifies, does not accurately describe the condition. In fact, a preoccupation with food, hunger, and eating persists in the midst of self-deprivation, but is denied, often strenuously (Garfinkel & Garner, 1982). Although the debate about the lineage of the modern anorectic patient remains unsettled, there is some consensus about the beginnings of nosological efforts.

Anorexia Nervosa: Evolution of a Diagnosis

Palazzoli (1963/1974) offers a comprehensive historical survey of anorexia nervosa in which four distinct periods are identified. The earliest detailed description of the illness, attributed to the English physician, Richard Morton, marks the beginning of the first period. His paper, "Of a Nervous

Consumption" (1694/1985), described patients in whom a lack of appetite and gradual weight loss persisted in the absence of other physical symptoms which might otherwise account for such developments. He further observed that this "nervous atrophy . . . does almost always proceed from sadness, and anxious cares" (p. 11). Publications by an English neurologist, Whitt, in 1767, and by a French physician, Nadeau, in 1789, also identified a condition marked by extreme weight loss due to restricted food consumption which sometimes proved fatal, as in the case reported by Nadeau (Palazzoli, 1963/1974). Time and geography separated these initial reports, but in the late nineteen century similarities in emerging clinical portraits sparked a dialogue across the English Channel on the subject of this new disease.

It is largely this discussion which characterized the second period identified by Palazolli (1963/1974) during which the term, *anorexia nervosa*, was introduced by London surgeon, William Withey Gull (Bruch, 1978). He gave a reading of his paper in 1873, the same year that Ernest Charles Lasègue published a paper in Paris, independently concluding that the aetiology of anorexia resulted from the influence of emotional instability on the mental functioning of the patient.

A refinement in understanding turned on the debate regarding the need to distinguish anorexia from hysteria, given Lesègue's use of the term "hysterical anorexia". Eventually it was observed that hysteria was often absent from clinical presentations in which anorexia was present and that this disease was, in fact, a syndrome which could involve a variety of abnormal psychic states. These and other clarifications definitively circumscribed anorexia nervosa as "a modern clinical entity" (Palazzoli, 1963/1974, p. 4) at the close of the nineteenth century.

The third period in the evolution of anorexia nervosa as described by Palazzoli (1963/1974) represents an unfortunate set-back in its diagnosis and treatment. Following the discovery of an endocrinological link with fatal emaciation, anorexia nervosa was too often misdiagnosed as Simmonds' disease, after the Hamburg physician, Morris Simmonds, who observed an atrophied pituitary in several autopsies between 1914 and 1916. Despite having established anorexia as a psychological disorder, physicians began to treat these same symptoms with injections of extracts and pituitary grafts, while compounding the confusion with additional diagnoses of pituitary-related cachexia. Palazzoli attributed whatever success these treatments may have had to "the suggestive powers of those prescribing" them (p. 8). It was not until the 1940's that H. L. Sheehan convincingly demonstrated that an impaired pituitary does not necessarily result in weight loss and that, conversely, emaciation does not necessarily imply an impaired gland (Palazzoli, 1963/1974).

The discrediting of a biological basis for anorexia nervosa restored it to its former status and cleared the way for the exploration of this syndrome's psychological roots, marking the last of the four periods described by Palazzoli (1963/1974). Despite the awareness of a psychological climate particular to anorexia, understanding of these dynamics had yet to be elucidated. Efforts were focused on the identification of a psychotherapeutic approach which could address the issues underlying self-starvation. Early speculation by Janet pointed to "the patient's refusal to play a feminine sexual role", a view echoed by Freud (Palazzoli, 1963/1974, p. 9), and developed by clinicians in their efforts to identify an aetiology of anorexia.

A review of the research up to the early 1960's led Palazzoli to conclude that of the more contemporary researchers, only Hilde Bruch's

conceptualization of "true" and "pseudo-anorexia" sub-groups had any merit as a clinical observation on which to base therapeutic interventions. True or primary anorexia is summarized as follows: " . . . 1) inability to perceive internal body cues; 2) delusional body image; and 3) a paralyzing sense of ineffectiveness (the cornerstone of her psychological diagnosis of true primary anorexia nervosa)" (Schwartz et al., 1985, p. 103).

Cases differentiated as "pseudo" or secondary anorexia were thought to represent those in whom dysfunction was associated more with sociocultural factors rather than with developmental deficits or traumas. The significance of this conceptualization was that it not only captured a clear delineation of the psychological profile of anorexia, but it also acknowledged the influence of the sociocultural context in which the incidence of anorexia nervosa was increasing.

The individual's immediate social context is the family, and those of anorectic patients had been observed to express a particular dynamic. In fact, as early as 1874, it was suggested that the patient be isolated from her family to promote recovery (Gull, 1874/1985). This relationship continues to be studied and addressed as part of the therapeutic process (Bruch, 1978; Crisp, 1980; Garfinkel & Garner, 1982; Stierlin & Weber, 1989).

Whatever difficulties are created in distancing the patient from the family, it is another matter, altogether, to isolate an individual from the social environment. The very nature of the anorectic's often referred to "relentless pursuit of thinness" demanded consideration of the relationship between the cultural context and symptomatology, a relationship which led Bruch to suggest the term "psychosociological epidemic" (Bruch, (n.d.), cited in Schwartz et al., 1985, p. 103).

The combination of escalating clinical presentations, research based on these cases, and a willingness to look beyond the usual parameters of thinking about psychopathology all contributed to what might be considered the fifth period in the evolution of anorexia nervosa. This most recent period is marked by the recognition that anorexia has a counterpart in bulimia nervosa, both of which are known today as eating disorders.

Eating Disorders: A Modern Diagnosis

Up until the mid-1970's there was only occasional mention of bulimia in the literature, always within the context of anorexia (Andersen, 1985). The acknowledgement that bulimic episodes may be an associated feature of anorexia eventually gave way to the discovery that more-or-less normal weight individuals also engage in binge eating. This prompted the official recognition of bulimia in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980.

The differentiating criteria for bulimia was a more moderate weight fluctuation without the life-threatening extremes associated with anorexia nervosa. No minimum period or frequency of binge eating was indicated for a diagnosis. Induced vomiting was mentioned only as one of four ways in which a binge might be terminated. Dieting and purging were named as ways in which to control weight, rather than as compensations for possible weight gain specific to bingeing.

Out of the body of research in the 1970's which helped to establish bulimia as a separate clinical entity researchers became aware of purging behavior as an accompaniment to a bulimic episode. Boskind-Lodahl & White introduced the term "bulimarexia" (1978, cited in Boskind-White, 1985) to designate the binge-purge syndrome. Furthermore, Boskind-White

maintained that "bulimarexia is not a disease; it is a *learned habit* fostered by an insidious socialization process which prepares women to accept weakness, sickness, and victimization" (p. 115). This perspective addressed not only the cultural context, but specifically conceived of it in feminist terms by citing the role of gender in socialization. This reading of the aetiology of disordered eating became more prominent in the 1980's and 1990's (e.g. Chernin, 1985; Orbach, 1986; Kearney-Cooke, 1991; Fallon et al., 1994).

Of perhaps greater significance in this discussion is that Boskind-White's statement is also a strong endorsement for a therapeutic approach based on cognitive-behavioral principles through which supposedly learned attitudes can be unlearned. This stands in contrast to the psychodynamic approach suggested by Bruch's conceptualization of "true" anorexia. However, it is of interest to note that the treatment of secondary or "pseudo-anorexia" may benefit from a cognitive-behavioral approach to the extent that it resembles bulimarexia in its presumed cultural influence on the development of symptomatology. These efforts to define causal factors had a direct impact on decisions about therapeutic approaches.

In the revised edition of the DSM III-R (1987) bulimia was redesignated as bulimia nervosa, with a description of types of purge behavior which may follow a binge. Also noted was the suggestion that vomiting may be the desired target event. For the first time a minimum frequency of episodes within a three month period was indicated.

A reorganization of the diagnostic criteria for both disorders included the possibile presence of a depressed mood in bulimia, in contrast to compulsive types of behaviour in anorexia. This clarification reflected research efforts to identify potential biochemical links with other psychopathologies, such as mood dysregulation in depression and obsessive compulsive disorders (Dippel

et al., 1987). It was thought that establishing such links might elaborate the aetiology of and differences between anorexia and bulimia. (Levitan, 1981; Dippel et al., 1987).

In the fourth edition of the DSM (1994) Pica and Rumination Disorder of Infancy were regrouped under "Feeding and Eating Disorders of Infancy or Early Childhood", leaving anorexia nervosa and bulimia nervosa the official classification of "Eating Disorders", a designation already in common usage by the media and the public at large. The relationship between bingeing and purging was definitively inscribed as "recurrent inappropriate compensatory behavior in order to prevent weight gain" (p. 549).

Knowledge accumulated from research and clinical treatment was reflected in the expanded descriptions and revised diagnostic criteria of both diagnoses. Anorexia nervosa currently includes two possible types, either restricting or binge-eating/purging type, and bulimia nervosa may be of a purging or nonpurging type. In addition, there is a new classification of Eating Disorder Not Otherwise Specified to recognize cases that do not meet established criteria (DSM IV, 1994).

Treatment: A Multi-Dimensional Continuum

Modifications to the diagnostic criteria were due, in large part, to a surge in clinical presentations of individuals with disordered eating behavior. This factor continues to stimulate research into the impact of disordered eating on physical and cognitive functioning. Efforts are also being focused on the delineation of the physiological, characterological, and environmental components of the patient population. One indication of the extent of the puzzle is an observation made in 1985 that still holds true more than a decade later: "eating disorders remain classified as syndromes; that is, they are

symptoms that can be reliably diagnosed, but we do not yet have a firm understanding of their fundamental cause" (Andersen, 1985, p. 4).

One may well question the use of a "fundamental cause" paradigm, especially given that the unidimensional perspectives (such as psychodynamic or biologic) used in the 1960's and 1970's have already been replaced by the application of a bio-psycho-social model of anorexia nervosa in the early 1980's (Andersen, 1985). This new model reflects the growing awareness of multiple contributors to both anorexia and bulimia. It also underlines the complexity of our enquiry and search for understanding of eating disorders.

In light of the recognition that multiple factors are evidenced in this group of symptoms, the significance of a multi-dimensional treatment approach cannot be overstated. Such a model encompasses the intrapsychic, interpersonal, and social spheres, as well as physiobiochemical, psychodynamic, and cognitive-behavioral functioning. What is of equal importance within the context of this thesis is a recognition of the varying degrees of symptomatology. This bears directly on an appreciation of the relative fragility of the patient. It is this fragility which determines the capacity to make use of a given therapeutic modality. To that end, a review of the current standard therapeutic interventions will clarify the nature of the symptomatology continuum which this population must negotiate and the role that group dream work can play in the patient's recovery.

The Role of Structure in Treatment

One way of conceptualizing the treatment of eating disorders is in terms of the patient's need for structure. There is a direct relationship between the degree of symptomatology and the kind of therapeutic structure which is indicated in order to promote the amelioration of symptoms. The most obvious

example is the criteria for hospitalization versus admission to an out-patient treatment program. Individuals whose weight has fallen to a life-threatening level are given a greater degree of structure on an in-patient unit compared to those with less severe symptoms. Despite having the same diagnosis, the latter patient demonstrates a greater capacity to function in the presence of diagnosable symptoms, whereas the hospitalized patient, whether anorectic or bulimic, may be thought of as being "out of control". In other words, the severity of symptoms has a direct bearing on decisions related to the structure of treatment.

Given the physical impact of this disorder, the first priority is to interrupt the eating behavior in order to reverse the effects of starvation, in the case of anorexia, and the effects of binge-eating and purging, in the case of bulimia. In the most extreme cases, hospitalization will be required. This intervention provides the greatest degree of structure. The regulation of food in-take is imposed by the institution until such time as the patient's health is stabilized. Weight gain, by itself, is only the first step toward improvement (Andersen, 1985). With the accomplishment of this goal, the individual can begin to think more clearly and, therefore, to engage in individual and/or group activities designed to stimulate discussion about the eating behavior. This represents an essential component of treatment at any level.

Rarely is an individual sufficiently improved to be able to return to her home environment without continued support. Following discharge, a patient may be referred to a day program, an outpatient clinic, or individual psychotherapy, at the very least. Obviously, this decision will depend on the availability of resources, but ideally, post-hospitalization treatment should be based on the patient's needs. This assessment is rooted in an evaluation of the

degree of structure which would most support the patient's consolidation of the changes in the eating behavior.

Fortunately, most people diagnosed with an eating behavior do not need to be hospitalized. Again, depending on the degree of symptomatology, the individual may need the support of a day program which he or she will attend several days a week. If the person is functioning well enough at work or school, participation in an outpatient unit, with access to a dietician, an individual psychotherapist, and/or a weekly psychotherapy group may be sufficient. Some patients prefer to engage only in individual psychotherapy, while the majority go undiagnosed for years.

Regardless of the format in which treatment is conducted, disordered eating must be addressed in a number of ways if the underlying issues are to be identified and successfully worked through. This includes the need for information regarding the effects of starvation and binge-purge behavior on the body and cognitive functioning. Also essential is an understanding of the kinds of cognitive distortions which may stimulate the emotional disequilibrium which provokes disordered eating (Herman & Polivy, 1975). Also important to explore is the patient's typically distorted perception of her own body (Thompson, 1990).

The patient's experience of food must be examined and, in most cases, re-evaluated with the help of a dietitian. This may include the need to develop sensitivity to bodily cues for hunger and satiastion, learning to plan a balanced meal, recognize normal food portions, how to buy and prepare food, and developing an awareness of the effect of one's emotional and social environment on eating behavior. Beyond these seemingly practical aspects is the recognition of what one patient referred to as "everything that is hidden underneath the plate". This phrase symbolizes the associated issues

which impinge on the patient's image of herself as a creative, autonomous individual worthy of life. These issues touch on the patient's relationship to family, friends and intimates, as well as career ambitions, all of which represent key components of a satisfying life.

The more physically and psychologically fragile the patient, the greater the need for therapeutic containment and structuring interventions in order to move towards the healthier end of the symptomatology continuum. The degree to which this is achieved will determine the patient's capacity to productively engage in a process as demanding and potentially rewarding as a dream group.

Eating Disorders and Art Therapy

A review of the literature since 1980 reveals a consistent emphasis by art therapists on several aspects of working with patients diagnosed with an eating disorder.

Many authors point out that art therapy can accommodate this population's need for control which is so central to their functioning (Mitchell, 1980; Haeseler, 1982; Murphy, 1984; Naitove, 1986; Levens, 1987; Woodall & Anderson, 1989; Schaverien, 1989). Control is exercised through the patient's decisions about media, about whether to discuss the images, and what to say (Mitchell, 1980). Verbal psychotherapy may provoke a sense of being forced to speak or to remain resistantly passive within an either-or-frame frame. In art therapy, the fact of having to make choices, of having options, becomes a way for the patient to engage without complete surrender. Murphy (1984) stressed that committing the first marks to paper becomes a declaration of the patient's engagement in therapy and, consequently, in recovery.

In turn, the concomitant need for approval is secured by the patient's (seemingly) willing participation in art therapy. Haeseler (1982) understood this deliberate act of compliance as giving control to the therapist, thereby mitigating the patient's anticipation of guilt or shame. Wurmser (1981,cited in Wolf et al., 1986) suggested that a failure to speak of inner feelings may reflect the need to protect the self against exposure to shame. By deliberately giving up control, the patient may feel less responsible for what is conveyed through the images.

Having negotiated these initial tensions, the patient then may experience a lowering of anxiety simply by creating a spontaneous image (Haeseler, 1982). This is attributed to the understanding that feelings, otherwise too overwhelming to admit, can be safely contained within the drawings. The ambivalence and confusion from which the patient tries to distance herself can be visualized and made available for clarification. By placing the focus on the image as the object of transference, as a mirroring self object, the patient may feel less threatened by the therapist and experience a measure of safety from difficult feelings which have been pictorially objectified (Murphy, 1984).

A unique advantage of art therapy is that the content of the created images can never be denied and is available for review. The image's physical existence contributes to the development of constancy which is crucial to a successful negotiation of separation/individuation as delineated by Mahler (1972; Levens, 1990). Over time this body of work affirms the actuality and substance of the patient's inner life and attests to the evolution of the therapeutic process through which a growing sense of self can emerge (Crowl, 1980; Haeseler, 1982; Murphy, 1984; Wolf et al, 1986; Schaverien, 1989).

Some authors think of these images as providing "feedback" (Levens, 1987, p. 5) to their patients which is more crucial than anything the therapist might have to say, particularly in the initial stages of therapy (Crowl, 1980; Mitchell,1980; Murphy, 1984; Wolf et al, 1986). This type of feedback parallels the kind of mirroring which another patient's comment in group verbal or art psychotherapy might provide. The shared culture of the group members renders the observation more significant and, therefore, more difficult to dismiss. The potential of this feedback is maximized in the Ullman model and will be discussed later in more depth.

A more extreme position is taken by Schaverien (1989) who suggests that interpretation "may not be beneficial" for anorectic patients (p. 17), given their need for unintrusive respect of their vulnerably rigid boundaries. Furthermore, Schaverien maintains that because the conscious content of an image is always outweighed by the unconscious elements, the latter will be "assimilated without verbal interpretation" (p. 17). Nonetheless, there is a consensus amongst the authors surveyed: Allowing non-directed graphic expression and holding back interpretations and questions, while responding with praise during the initial stages of art therapy contributes to an accepting, non-threatening milieu. The establishment of such an ambiance makes it possible for the patient to take the crucial step of introducing his or her own ideas, opinions, and memories. (Crowl, 1980; Mitchell, 1980; Haeseler, 1982; Murphy, 1984; Wolf et al, 1986; Levens, 1987; Schaverien, 1989; Luzzatto, 1994). With the development of a sense of on-goingness or constancy, words can more readily embody images and ideas, making it possible for the individual to function increasingly on a more abstract level.

Art therapists have integrated a variety of theoretical references, already in use in their clinical practice with other populations, which are relevant to

the current understanding of the developmental issues in eating disorders. For example, Sours' (1980, cited in Wolf et al, 1986) formulation of the anorectic's tendency to respond to psychological issues with concrete solutions is understood as evidence of a failure in the separation/ individuation stage of development as articulated by Mahler (1972). Given the largely pre-verbal time frame of the initial stage, separation is negotiated physically rather than verbally, stressing the primacy of kinesthetic/somatic self-expression. With the return of separation issues during adolescence, the earlier failure is thought to handicap the adolescent's negotiation of a more mature autonomy because of an underdeveloped capacity to function at an abstract, psychological level, as suggested above. A concrete approach to problems may be favoured, even (and perhaps, especially) when abstract dilemmas such as separation are concerned.

It is precisely this recourse to the physical which makes art therapy a suitable therapeutic intervention with this population. As previously discussed, some art therapists draw on Kohut's conceptualization of the self-object and regard the image as a psychological mirror reflecting the patient's, as yet, unexplored inner world (Haeseler, 1982; Wolf et al., 1986). Furthermore, the tendency to resolve psychological issues via concrete, physical means suggested to Wolf et al. that this developmental failure in separation/ individuation may also shape what Bruch (1973) identified as the attendant difficulties in recognizing and articulating internal feeling states, as this task demands a translation of a physical experience into abstract terms.

This task calls for the capacity to understand one's body as a source of physical and emotional experiences and to be able to differentiate the two.

Therefore, engaging in undirected image-making allows the patient to begin to identify the imaged feeling states as her own and to develop a sensitivity and responsiveness to them. Out of this process, the patient, with the help of the art therapist, can begin to delineate a conceptualization of the underlying dynamics, a conceptualization which is clearly unimposed, and therefore, authentic.

The resulting self-awareness can contribute to the development of an identity aligned with feelings, rather than with the need for approval and/or control. The discussion of previously unmanageable feelings can become possible and ultimately may lead to a consolidation of the patient's mastery over impulses. Schaverien's (1989) conceptualization of food as an object of transaction between the patient and him or herself and others suggests that the process of image-making can become the arena in which transactions with the inner and outer environment are mediated, allowing the patient's obsession with food to gradually give way to a more autonomous mode of functioning.

It is understood that despite the patient's apparent control in choosing what to disclose, unconscious conflicts will emerge in the art work. This phenomenon facilitates the art therapist's understanding of the patient's on-going process and the choice of an appropriate moment in which to bring these conflicting emotions to the patient's attention. In one instance, a mix of creative art therapies supported a hospitalized patient's need for control while providing the treatment team with their only means of understanding the patient's dynamics, as he was being treated at some distance from his family (Naitove, 1986). It must be remembered, however, that the patient may recognize the conflictual issues depicted in the image without the therapist's explicit intervention (Meyerhoff, 1986).

Art therapy addresses this population's need to maintain control over their engagement in the therapeutic process while making possible a gradual acknowledgment of conflict and the exploration of the relevant issues. By providing a non-verbal, kinesthetically related means of self-expression, art therapy facilitates a reworking of separation/individuation issues, thereby contributing to the patient's development of higher level, symbolic communication and the consolidation of identity based on self-awareness and the capacity to negotiate needs.

Eating Disorders and Dreams

In answer to the question whether patients with an eating disorder actually remember their dreams, the evidence is certainly clear that although this popluation has less dream recall than normal subjects (Frayn, 1991), dreams are remembered more frequently by these patients than by those diagnosed with major depression (Dippel et al, 1987). Furthermore, it is interesting to note that, outside of the research literature, dreams are invariably present in most, if not all texts which describe clinical work with this patient population (Palazzoli, 1963/1974; Bruch, 1978: Crisp, 1980; Chernin, 1985; Robertson, 1992).

Dream research has taken up a variety of questions related to those diagnosed with an eating disorder. Studies include an investigation of biological links to other clinical populations (Dippel et al, 1987), attempts to decipher the psychodynamic differences between anorexia and bulimia (Levitan, 1981; Dippel et al, 1987), as well as efforts to identify the prevalent unconscious conflicts through content analysis of the manifest dream (Brink & Allan, 1992).

Analysis of dream content not only differentiated the psychodynamic functioning of those with an eating disorder compared to a non-clinical

population (Brink & Allan, 1992), but also supported conceptualizations regarding the differences in psychodynamic functioning of anorectic and bulimic patients.

One study is worth mentioning in more detail as it comes closest to the spirit of this thesis. Frayn (1991) addressed the relationship between the role of excessive repression in anorexic patients' alexithymic estrangement from their feelings and fantasy life and the assumption, in psychodynamic dream theory, that dream recall is reduced by excessive repression. Among other findings, this study demonstrated the prevalence of body image distortion in the dreams of anorexic patients, an uncommon feature in the dreams of normal control subjects. When coupled with weight gain during the course of treatment, this dream element seemed to predict treatment outcome, depending on the type of body image distortion reported in the patient's dreams. In addition, it was concluded that improved recall and increased measures of the degree of perceptual awareness (such as colour and kinesthetic sensations), may inform the assessment of anorexia nervosa by providing an additional window onto the severity and evolution of the syndrome.

However, dreams are more than potential tools for the pursuit of refining our understanding of this population. The observation that these patients "characteristically . . . avoid intrapsychic exploration and experience introspection as unpleasant and/or irrelevent (Frayn, 1991, p. 520), suggests that the improved recall which results from sensitizing a patient to dreams may be the first step in developing an awareness and interest in an inner life. Brink & Allan (1992) noted that the patients in their study readily agreed to report their dreams while resisting other therapeutic approaches to exploring their feelings. This was thought to reflect the patients'

understanding of dreams as unrelated to personal issues. As such, discussing dreams permitted a relationship with the therapist while supposedly avoiding unwanted self-disclosure. One assumes that over time these patients were able to acknowledge the very real relationship of their dreams to themselves, as well as the benefits which may have accrued from discussing their dreams with another.

Eating Disorders, Art Therapy, and Dreams

The portrait that emerges from the above review of the literature on individuals diagnosed with an eating disorder indicates that art therapy is an appropriate treatment approach for this population. It allows them a necessary degree of control (Mitchell, 1980; Murphy, 1984), aproval (Haeseler, 1982), and safety (Crowl, 1980; Levens, 1987; Schaverien, 1980; Luzzatto, 1994). Images can also take on a mirroring function, reflecting the patient's inner life with an authentic authority which supercedes that of the therapist (Levens, 1987). This facilitates the exploration of various feeling states which are considered too threathening to acknowledge.

There is also support for the notion that working with these patients dreams can provide a means to sensitize them to the fact of their inner lives. The combination of drawing and dreams provides a structure in which this population can exercise control over what they reveal and what they are ready to recognize about themselves.

The Contribution of Safety to the Pursuit of Discovery

In considering the possible drawbacks of working with an integrated model of dreams and drawing, one may question whether the model facilitates the dreamer's evasion of the very issue which the dream is articulating, that is to say, that it permits defensive avoidance of issues. The decision to share a

dream can be thought of as a reflection of lowering of defenses (Ullman & Zimmerman, 1979), not unlike the decision to relate a fantasy or daydream within a therapeutic context. Having to decide whose dream will be shared can be said to allow the dream group members an opportunity to reevaluate their ambivalence and withdraw the dream if it seems more appropriate to do so. For the individual who does go on to share a dream, the initial lowering of defenses is furthered with the actual reporting of the dream (Ullman's Dream Seminar, July, 1991). The sharing of the dream moves it out of the realm of private, self-contained intrapsychic experience into the public domain of interpersonal communcation. This socialization of the dream content may be thought of as an implict commitment to discovery.

The collective "owning" of the creates an opportunity for the dreamer to be exposed to ideas against which he or she may be defended, but because these possibilities are identified as someone else's projections, the dreamer may be more open to recognizing a similarity in his or her own response to the material. Art therapy provides an example of this in which group members are encouraged to project onto each other's drawings. Each group member's image is considered a "shared vehicle" for sexual and/or aggressive fantasies with which the image maker need not identify "unless ready to do so" (Levens, 1990, p. 281).

It is arguable whether the phenomenon of a "felt sense", as articulated by Gendlin (1978), can be experienced by dreamers who are diagnosed with an eating disorder, but it is one level of response which undeniably communicates to the dreamer a recognition of something alive and relevant. Regardless of the nature or content of the dreamer's awareness, this approach dream work and drawing supports the option to keep private any or all responses to the group members' associations. Unpleasant insights may be

explored later, either alone or with a selected individual. Afterwards, if the dreamer feels sufficiently comfortable, this material can be shared at the start of the following dream group.

This speaks to the two fundamentals of "safety" and "discovery" on which Ullman's approach to dream work is based. The dreamer's freedom to say as much or as little as is desired provides a symbolic safety valve in regulating the anxiety of being confronted with the dream's revelation so that the discovery can be accommodated rather than denied. This structure allows the dreamer successive appraisals of his or her anxiety relative to the understanding of the dream.

The added advantage of this group structure is the opportunities it can provide for modeling the capacity to acknowledge seemingly unpleasant aspects of oneself. Some members may be less defensive than others. Being an observer to someone's spontaneous insight can be a powerful motivator to challenge oneself.

In any case, the dreamer is always working at the least defensive level of which he or she is capable. By observing more adventurous dreamers survive self confrontations and noting the benefits that can accrue, the more defended dreamer may be persuaded that considering metaphoric associations somewhat farther afield from one's comfort zone can be more rewarding in the long run. It becomes a risk-taking proposition through which the dreamer always profits.

Over time, the practice of dream work and drawing can acclimatize the dreamer to avoided issues through a gradual lowering of defences that evolves at the dreamer's pace. In this sense, the "safety factor" supports the unfolding of a manageable pace at which defenses can be identified and adapted.

Ullman's Model of Group Dream Work

This is a 'closed group' model in which membership is voluntary and fixed for the duration agreed on by the participants. The group can disband or chose to accept new members at a particular moment, after which it is, once again, closed. These options secure a stable membership which helps to promote a focused atmosphere conducive to a feeling of safety.

It is not uncommon for several members to arrive with the decision to share a dream. In this case, the dreamers decide amongst themselves with whose dream the group will work. Vivid dreams from the past have been satisfactorily understood through this process. However, the more recent dream enhances the possibility of discovery, as the dreamer is more likely to remember pertinent details surrounding the context in which the dream arose.

Stage I: Sharing the Dream and Clarification

Once a member has volunteered a dream, she begins by indicating the day on which the dream occurred and relates the complete dream in any tense. The dream may have been recorded in text or may be related from memory. Then the group can ask for clarification of content, but no associations of any kind are to be elicited. Clarification relates strictly to the the task of enabling the participants to have as complete a grasp of the dream as it is remembered by the dreamer. To that end, dream characters known to the dreamer in real life are briefly identified. However, some questions will remain unanswered if the dreamer is unsure or does not clearly remember.

This is followed by the clarification of feelings in the dream, as well as on awakening. It is recommended that participants write down the dream as it is

being told. This will facilitate the integration of additional material which will follow.

Stage II: Ownership of the Dream

In this stage each participant reflects on the dream as if it was his/her own. In order to facilitate this process, comments are directed solely at other participants. Active exclusion from eye contact enhances the dreamer's disengagement, allowing her to sit back, listen, and make notes for response to the group at the next stage. For now, the dreamer will interrupt only to correct any distortion of a dream image or to add information about the dream which is spontaneously remembered.

The participants first try to identify a specific image or mood of the dream as they understand it. They are free to include their own projections as a means of articulating a personal response to the material. The concept of ownership includes the members' active acknowledgement of their projections by use of such phrases as "If this was my dream I would feel ..." or "Dreaming about ..... always makes me feel .....". The goal is to engage imaginally with the dream content, using any theoretical system to further the metaphorical range of possibilites for the dreamer's consideration. The group moves from reflection on the general mood or signifying image of the dream to the elaboration of whatever other dream elements capture the participant's imagination. Ideally, all significant components will be referred to by at least one group member.

These offerings are at the disposal of the dreamer. In order to avoid information overload, it is recommended that only the ideas or interpretations which resonate with the dreamer should be noted. This will help move the dreamer deeper into the meaning of the dream.

By sharing projections the group is sharing their psyche, just as the dreamer did in sharing the dream. Collective self-disclosure helps to build trust and to promote safety.

Working through these two stages can bring a sense of closure to the dream, although more work and dialogue is often required.

Stage III: Dreamer's Response

Once the group has sufficiently explored the dream content, the dreamer is invited to respond to the members' input in whatever manner seems appropriate. This includes the freedom to start with an image or from any point in the dream; to respond to as many or as few of the projections as desired; to refute or modify associations; to ask how a member arrived at an association; or to remain silent and reflect inwardly on some or all of the possibilities. It is essential that the dreamer remains the final arbitrator of what 'fits' or doesn't.

The dreamer's train of thought must remain undisturbed during this stage. The only reason to interrupt the dreamer is in the event that what is said can not be heard. The dreamer remains in control of the process by taking all the time needed to satisfactorily respond to the material. Therefore, Stage III continues until the dreamer has nothing further to say.

Stage IV: Eliciting Context of Life Situation

Questions from the group in this stage are meant to help the dreamer reconstitute the life context in which the dream arose, with an emphasis on feelings instead of facts. Rather than information seeking, the purpose is to facilitate exploration of the dreamer's psyche. To this end, questions are simple (e.g. "What feelings did you go to bed with?"); evoke the dreamer's "feeling diary" (e.g. "Did you have any arguments, or did anything excite you before this dream occurred?"); and redirect a factual response for further

reflection to facilitate a possible emotional connection (e.g. "Is there anything more you would like to say about that?"). These open-ended questions allow the dreamer's thoughts to circulate freely without being led in any particular direction. As in Stage II, a thought might come which the dreamer may chose not to share.

Stage V: The Playback

Now that the day residue has been identified and integrated with associations designated by the dreamer as meaningful, the dream is read back to the dreamer, scene by scene, using the second person singular (i.e. "you"). This manner of restating the narrative in the voice of another (i.e. from "I" to "you") objectifies the experience of the dream event for the dreamer. This distancing, or shift in perspective, may result in further associations as information from the first scene is carried into the second, and so on.

Stage VI: Projecting and Integrating

The dreamer is asked to amplify whatever images seem to be in need of further exploration.

Stage VII: Orchestration

The task of this closing stage is to offer an "integrating projection" which is meant to connect the valid associations with the relevant details of the dreamer's life context. Once again, the group resorts to projection in order to orchestrate a meaningful, consistent reading of the way in which the dream reflects life situations with which the dreamer is currently preoccupied. As throughout this process, the dreamer is the final arbiter of an orchestration's meaningfulness.

One member may go through the entire dream or may chose to offer an orchestration of a particular scene. It is important to stay with what the

dreamer has given without adding new material or including associations which the dreamer had refuted.

The dreamer should be encouraged to re-examine the dream afterwards. Solitary reflection may result in the acceptance of associations previously denied or the rejection of interpretations that had been accepted.

Delayed Orchestration

Some dreams are more readily illuminated than others. If no closure takes place during the time available, the leader can offer a delayed orchestration. The dream is reviewed scene by scene, using the dreamer's comments from each stage of the process, in an attempt to create an orchestrating projection.

The leader makes use of those comments which have stimulated a seemingly coherent line of interpretation. However, it still remains a projection, and the dreamer is advised that it can be rejected or accepted, in whole or in part.

Post-Session Follow-up

The next group meeting begins with a response from the dreamer to any thoughts which may have surfaced since the previous dream group.

Description of Model Versus Application

The foregoing description would be incomplete without emphasizing that it represents the most detailed delineation of the process based on Ullman's training seminar. In practice, the actual application of the model generally transpires in three clearly observable stages. The first two stages (sharing the dream and ownership of the dream by the group members) have an explicit beginning and end, whereas Stages III, IV, and V (the dreamer's response, eliciting context of life situation, and the playback, respectively) are compressed into a final phase of dream work which takes the form of a dialogue. During this third stage, the dreamer uses the group's questions to

arrive at a sense of closure regarding the dream's meaning (Ullman, 1979). Stage VI and VII (projecting and integrating, and orchestration) are extended forms of this dialogue and represent the group's final attempts to organize a projective integration of the dreamer's associations in order to bring the dream work to a close.

The final stages of orchestration undoubtedly represent a high level of skill which few possess naturally and which not every member will develop. However, like any creative process, an on-going practice is sure to sharpen one's fluency and expressive range so that everyone who willingly engages in dream work will grasp the necessary skills and master them in his or her own way. The concept of offering an integration or orchestration of the salient associations and day residue can be thought of as the summit of the creative challenge posed by the desire to understand dreams, not unlike the attempt to create with paint, charcoal or clay the image which one beholds in one's inner eye. More often than not, like the arts, dream work remains incomplete or approximate, but nonetheles, can leave the dreamer with an unanticipated understanding of the inner event.

Integration of the Drawing Response to the Target Dream

The introduction of a drawing response within Ullman's model represents an art therapy approach to dream work. Its placement within the model reflects its function as part of the projective response to the target dream. It was thought that Stage II (the group's verbal associations to the target dream) would stimulate the participants' imaginal faculties and prepare them to engage in drawing. Therefore, after the members' associations to the dream, the drawing task will be introduced by a verbal directive as follows: "Choose a part of the dream which is most interesting to you and make a drawing".

In principle, the aim was to allow each participant the freedom to draw whatever was most subjectively compelling about the dream. This pictorialization might elaborate the member's verbal projections or those of others, or allow for material which the member had not yet identified verbally. In considering the drawing as a non-verbal association, it was decided to follow the drawing task with the dreamer's response to the drawings (i. e. without hearing any of the members comments). This would be a reversal of Stage II (during which members project onto the dream) and a bridge to the beginning of Stage III (the dreamer's response to members' associations).

Consistent with the theoretical underpinnings of art therapy outlined above, it was anticipated that these images might reveal an affective response to the dream not readily identifiable or deliberately elaborated in the verbal projections. It was also thought that the the composition of the group (patients in treatment for an eating disorder) might contribute to thematic commonalities that could be observed in the drawings. For the dreamer, the drawing would be a first opportunity to organize a response to the material generated since the sharing of the dream. This might include the dreamer's own insights on sharing the dream (a phenomenon noted by Jung, 1965), as well as those resulting from the group's projections.

In light of these considerations, there was some speculation as to whether the additional stimulation of the dreamer's associations, resulting from the inclusion of a drawing response, may contribute to a sense of closure which is sometimes achieved at this point (i.e. with the dreamer's review of the group's associations in the third phase - Stage III, IV, and V). Elements of a response to this question, based on the observations made during the study, will be addressed in the discussion

Applicability of Model to Clinical Population

This hybrid model of group dream work and drawing represents an organization of two fundamental components of art therapy, the unconscious primary process out of which dreams and drawings arise, and the structuring secondary process which is the manifest dream and the finished drawing. The decision to integrate drawing with a structured approach to working with dreams, used in the lay community, represents the understanding that the opportunity for creative expression inherent in art therapy offers a bridging function between non-verbal and verbal processes. This speaks to the relationship between remembered dreams and spontaneous images, both of which reveal the affective quality of current issues with which the individual is preoccupied, albeit at a pre-conscious level. As Ullman (1979) maintains, remembering a dream is an indication of readiness to confront the content. While this does not eliminate resistance, it does suggest that the defensive stance is open for reconsideration by the dreamer, perhaps in the same way that a spontaneous image announces the readiness to explore unexamined aspects of current issues. The application of this integrated model could benefit those at the end stage of treatment for an eating disorder.

An eating disorder implies certain qualitative aspects in the life experience of patients so designated. This commonality can be thought of as a shared culture, a feature which enables each member to contribute a level of understanding in the sharing of dreams (Ullman, 1973) which may not be possible for those outside this or any clinical population. If this is so, there may be an advantage to working with dreams in a clinical setting in which patients share a diagnostic category.

Given the structured nature of this integrated model of dream work and drawing, compared to a more conventional art therapy group approach, it

was thought that the trial application of this model would best be suited to those at the end stage of treatment. This takes into account a higher level of ego functioning than might be available at an earlier stage. For those nearing discharge, the use of creative expression may stimulate self-awareness in the context of group dream work which does not make use of clinical expertise, but relies, instead, on the contributions of group members. It was also questioned whether patients in the termination phase of treatment might be interested in an approach to dreams which could be continued beyond the clinical context.

Contextualization of the Study

The first application of this integrated model of dream work and drawing within a clinical setting was intended for a voluntary group composed of patients, either recently terminated or soon to be discharged from the Eating Disorders Unit of a large psychiatric facility. However, the services of an art therapy intern were needed with the hospitalized patients of this unit, so it was decided that the study could be conducted in that context. Despite some misgivings, it was thought that the in-patients might still benefit from the experience.

At the very least, it would be an opportunity to answer first hand some basic questions about the relationship to dreams of patients in treatment for an eating disorder. This included questions regarding the capacity for dream recall, the willingness to share dreams in a group, and the extent to which these patients are able to engage imaginally in dream work. There were also questions of a higher order pertinant to this approach, including the extent to which the "safety" and "discovery" factors facilitate productive dream work in a population which tends toward isolation and secrecy; what, if any, insight do the participants gain by engaging in this process; and what can group dream work tell us about this population as a whole? The study was also give an opportunity to reflect on the use of drawing as a source of non-verbal projection/association to the target dream.

The description of one session which follows and its subsequent discussion provides a basis for elaborating the strenghts of this approach to group dream work, as well as the limitations which must be respected if this process is to benefit the participants.

Clinical Setting

The Douglas Hospital is both an acute care and a long term psychiatric facility which includes a comprehensive Eating Disorders Unit made up of an In-Patient Unit (IPU), a Day Program, and an Out-Patient Unit (OPU). This tripartite model represents a continuum of patient care which includes the needs of those in an acute state of dysfunction, as well as those who are able to function at work and/or school with the support of the OPU.

The six bed IPU is for individuals who have reached a critical state due to extreme emaciation or non-stop bingeing and purging. The immediate goal in this unit is to interrupt the dysfunctional eating behavior, to introduce normal, healthy food habits, and to stimulate reflection about past behavior and the here-and-now experience. If acutely anorectic, the patient will have to reach a baseline weight before being permitted to engage in unit activities; otherwise patients are expected to participate in the unit's daily routine, including all therapeutic activities. With an emphasis on a cognitive-behavioral model, the ultimate goal is for the patient to stabilize at a weight appropriate to her height and build by eating nutritious meals and partaking in moderate activity. Release from the unit usually includes admission to the Day Program or the OPU, depending on the degree of structure required by the patient at the time of discharge.

The treatment program in the IPU includes a combination of individual and group work, with the emphasis on the group. Each patient is assigned a primary nurse with whom to meet on a regular basis and who is available in times of crisis. The unit functions on a schedule to which each patient is expected to adhere. Wake-up and bedtime, meals, therapy, free time and unit meetings to organize outings are all part of the weekly schedule.

At the time of this study, the therapeutic activities on the unit included: a weekly verbal therapy group conducted by one of the staff psychiatric nurses; life-skills orientation facilitated by the staff occupational therapist; a group given by the staff dietitian on various aspects of meal preparation and consumption; an art therapy group conducted by a trainee; bi-monthly family meetings which included all the patients and their family members, led by the staff social worker; and weekly outings to movies or other entertainment.

Structure of the Dream Group

Patients are admitted to the unit as soon as a bed is available, and they are discharged on the basis of individual progress. This results in periods during which the unit membership is in flux. In order to assure a fixed membership for the duration of the dream group, the introduction of the study was delayed until the unit admissions were certain to be closed for a minimum of eight weeks.

Prior to the dream group, a weekly art therapy group was conducted in which the patients addressed suggested themes based on their current experience in the unit. For example, on arriving one morning to discover the patients mulling over the group family meeting the previous evening, it suggested they explore their thoughts and feelings by making a drawing of the event. This work began May, 1995 and continued until the end of June, when the unit membership stabilized. The group consisted of six patients who will be referred to as Angela, Laurie, Margaret, Hanna, Jody and Sue.

Angela was an attractive woman in her early twenties who alternated bingeing with periods of deprivation. Occasional scars marked episodes of minor self-mutilation which served to ease frustration not alleviated by

purging. I first met Angela during my work in the Day Program. Her arrival to the in-patient unit the third week of June reflected a worsening of her condition and the hope that more containment would facilitate lasting gains. Laurie, a solidly built woman in her early twenties who abused laxatives and diuretics, was also diagnosed with bulimia. Margaret had the beginnings of a successful carreer in banking, but was severely debilitated by non-stop bingeing and purging. Hanna, in her thirties, had been anorexic for half her life. Like Angela, these three patients had participated in the Day Program prior to admission to the in-patient unit. The remaining two patients, Jody and Sue, were the youngest members of the group. Both diagnosed with anorexia, they were admitted directly to the unit a week apart at the end of May, in extreme states of emaciation. Because the average length of treatment is about three months, Hanna's admission at the end of June was to be the last for some time.

The following week, the patients were introduced to the idea of working with their dreams. One session was spent discussing dreams, dreaming, and dream work, including the drawing of dreams as a way to access meaning and deepen understanding. This "introduction" was also intended to stimulate the patients' thinking about dreams and, therefore, to stimulate dream recall. Standard suggestions for remembering and recording dreams were also discussed.

A total of four dreams were shared over five weeks. Given the volume of material which is generated by the sharing of one dream, it was decided to focus on one session, the fourth, in which a dream was shared by Sue. As is elaborated below in the discussion, this dream and the group's response to it best illustrates the potential benefits and unavoidable drawbacks of using this method with an in-patient group.

Collection of Dreams and Drawing Responses

As in any dream group, the participants in this study were instructed to write out the dream on waking or as soon as possible afterwards. In the absence of a written report, the dream could be described from memory. Clarifications are integrated into the dream report, whether written or verbal, and spontaneously remembered information is indicated as such.

A written record of each dream resulted from the transcription of the verbal report given during the group and was elaborated by additional information made available from audio recordings of each group.

All response drawings were collected following each group. Photographic slides were made of the drawings for each target dream and the drawings of each participant to all target dreams. The drawings were returned to the group members two weeks following the end of the study.

Drawing Materials

The specific materials for the execution of the drawing response included manilla paper (18" x 24"), as well as a range of twelve color pastels (dry and oil). These choices provide an average-sized drawing surface and media which allow both control (oil pastel) and flexibilty in application (dry pastel).

Use of the Drawings

While the placement of the drawing response within the model remained at the end of Stage II (after the group's associations to the dream), the actual use of the drawings was explored from one dream group to the next. The following sample session describes a version of working with these images which is in contrast to the intended use as originally indicated above. The reasons for this modification will be taken up in the discussion which follows the description of the application of the proposed integrated model of dream work and drawing.

Sample Session - Sue's Dream

Stage I: Sharing the Dream

Sue offered to share a dream she had three nights previous, about midweek between the last group and this one. What follows is the verbatim from the recorded session. "I don't remember much. All I remember is that I was horse back riding and I went ... uh, ... I don't know. I think I was trying a new horse and I remember riding it around my own stable and the horse talked and I was really upset that the horse could talk because I didn't want it to ... I didn't want it to talk. I wanted it to just be like a horse. It doesn't talk back. You just ride it and ... I remember then, I was just sitting in the trailer and the horse was on the other side and I had an apple in my hand and I was making sure that I could give the horse an apple because I really wanted the horse to like me. I really ... It was really important, but I was so upset that he could talk because that was, you know, it wasn't the same thing. And at one point, the horse was talking. And the horse, (laughing) I'm sorry , it was Hanna [another member of the group]. The horse was Hanna! And I was trying really hard to get the horse to like me, making sure that I had apples for it ... and that's basically all I remember.

During the drawing response, the dreamer added one correction. "We were riding and then all of the sudden we were in the trailer and I had the apple in my hand. I was sitting on the floor."

Clarifications

In response to a request for clarification about the horse, Sue could not describe it, beyond saying that she thought it was a brown horse, but she didn't really remember.

Sue did not recall any specific feelings when she awoke in the middle of the night. She simply wrote down the dream and went back to sleep. In the

dream itself she felt "really anxious, upset that (the horse) could talk". She also felt frustrated. She wanted the horse "to be like a normal horse", and she felt "anxious to make it like (her)". When asked if there was anything else she wanted to add, Sue thought that some of the other members were also in the dream, but couldn't remember clearly enough. It also seemed to her that there was more to the dream, as if the horse also may have been other group members, but that was unclear. It was suggested that, given the uncertainty about these other elements, it was best to stay with what she did remember.

A clarification about where she was riding led to a description of being on a trail, at the top of a hill, heading down. She was riding on a rocky part of the hill, inbetween two jumps. There was a stream at the end of the hill, and after the stream was a big field, then a parking lot where the horse was in the trailer.

Additional clarification included the following details. Sue seemed to be about 12 years old in the dream. She described the weather as "nice enough, a little cloudy" . In response to the statement "You said the horse looked like Hanna", Sue replied "No, it was Hanna". She specified that the horse sounded like Hanna. This was in the latter part of the dream, in the trailer, when Sue couldn't see the horse, but knew that it was Hanna.

When the need for clarification had been satisfied, the group was moved into the next stage of the process during which Sue would sit back and listen to how the others experienced her dream, making note of anything that seemed relevant to her.

Stage II: Ownership of the Dream

In asking what were some of the overall feelings in the dream, it was Sue who responded immediately, saying she felt disappointed. This was added to her other statements about her feelings in the dream. Sue was reminded that

the group was now in the next stage of the process in which the others would talk about her dream as if it was their own.

As no one volunteered to start, I began this stage with my version of feelings in the dream. I described myself as exhilarated at first, about engaging in my favourite sport, but then I became irritated when the horse talked. I began to feel aggravated; I didn't know what to do. I thought that someone was playing a trick on me and felt confused. Laurie described herself as scared by the talking horse because a normal horse has a small brain, and if this one could talk, then it's brain must be quite large. Laurie was afraid that this horse would hurt her somehow. Angela spoke about feeling a loss of control. She normally uses apples as a way to get close to horses, but she was not sure if apples were a way to make herself liked by Hanna.

At this point in the process, Jody, who had not spoken since the decision was made to work with Sue's dream, said that she felt nauseous and was going to go lie down. Jody's departure may have been a somatization brought on by the feelings that were being suggested in response to the dream, not the least of which was the feeling of fear and the feeling of losing control. This point will be taken up in the discussion below.

Following Jody's departure the group was silent. In an effort to help the group refocus on the dream, I picked up on the last patient's projection by saying that I know how to make a horse like me, but I don't know how to make a person like me. Margaret then said that she felt disappointed in the dream because horseback riding is her favourite sport: It's a source of comfort, pleasure, and freedom. But riding on a horse that talks "ça c'est une autre histoire" (that's another story). Margaret feels totally confused by this and

feels like nothing makes sense. Angela then adds that a talking horse makes her feel very nervous.

I suggest that the horse is an intelligent animal that notices everything and can find a way to express itself. It is surprising that the horse/Hanna speaks, even though I know it/she has something to say. I add that the horse/Hanna is someone I don't know well. Margaret adds that she would like to know Hanna better.

Hanna joins in by saying that she thinks that animals do think in their own way, that they know if they like us or not. She thinks that horses can really communicate feelings. In response to this, I add that animals are genuine in their expression of emotional states compared to humans who may say one thing and think or feel another. This is something I admire about animals.

Additional Dream Material

Sue spontaneously remembered a latter part of the dream, a not uncommon occurence. "When I was sitting in the trailer, it was like I was closed off and the horse was on the other side. It was a person: it was Hanna. And then I'm not sure if it was Hanna again. I mean this horse just kept changing, being a person and then not. I wanted to give the horse the apple. I wanted to make it like me. I remember sitting there and breaking the apple, but somebody else had taken over the horse, somebody else was talking with it, somebody else was taking care of it, that kind of thing. And I was just sitting in my part of trailer, wanting the horse to like me, but being terribly upset that it talked." Hanna asks, "And that it was talking to somebody else?" Sue replies, " I don't know if it was talking to somebody else or what was happening. I just know that I couldn't get close to it and I just wanted to make it like me. I had tried before when I was riding it, and the whole thing. And I just know it was

being taken away from me ..... Actually I think the person might have been Laurie .... I'm not positive."

I ask about the feeling in this part of the dream. Sue explains that if she is the only person, then the horse has to like her, but "if someone likes someone else, then there is no room for me. It makes me feel sad." Having said this, Sue adds that she is "pretty sure it was Laurie".

This new material is then taken up for projection. The members are silent, so I volunteer something to demonstrate that this can be discussed. I say that Laurie knows how to talk to people, has interesting things to say, and that people could like her in a way that they couldn't like me, even if I offered them things. I just wish I could be more like her, then I wouldn't have to worry about losing people I like because they would like me anyway.

Laurie follows with her own projections of feeling sad that horseback riding, the only thing that had been a "sure bet", had been taken away by someone else. "I would say, damn her". In playing with this idea, I add that every time I think I'm getting close to making a connection, something happens. Maybe I take too long, so that by the time I'm finally ready, it's too late.

Addressing the Silence

A long silence follows. I'm not sure what's going on. There was a noticeable silence after Jody's departure. Is this about the dream, about the relationship between Sue and Jody, or about having to reveal something about their thoughts about each other? I share my impression that there is a feeling of heaviness in the group. One member immediately refers to the heat (it is a muggy, humid morning) and she is quickly seconded by several other members, one of whom says she didn't sleep much last night. The weather is held accountable for the energy drain, a feeling of impatience,

and the wish to be outdoors. I admit that the humidity is a strain and add that there may be other reasons for feeling like it's hard to talk or to share our thoughts. It may have to do with the fact that todays's dream involves members of the unit and that this can make things a little "delicate" (offers Hanna). It is agreed that this is a good way to characterize the situation.

I attempt to distinguish between a dream about the real person and a dream in which a particular individual is used to say something about the dreamer (subjective and objective levels of meaning). The importance of sharing ideas about the dream elements is reinforced as the only way to gain understanding.

Laurie then volunteers that she identifies with the dream Laurie's behavior. Sue responds that learning about Laurie's horseback riding (in real life) makes her jealous. "I'm not angry at you. I just feel like a failure." I suggest that the jealousy may be related to a problem of distinguishing oneself, of wanting to be the only one in possession of a particular skill or relationship.

Drawing Responses

The use of these drawings varied as the dream group progressed. The reasons for this are addressed below. In this particular session, once the response drawings were completed, each patient spoke briefly about her image while the dreamer listened before speaking about her own drawing. Each member's comments about her response drawing follows in the order in which it occured in the dream group. The response drawings to which the comments refer are located in the appendix.

Margaret: I'm about to offer the apple and discover that the horse can talk. I'm frozen on the spot as the horse talks. [Figure #1. - horse is facing away from the figure]

Angela: I'm very pleased with the discovery that the horse can talk. I'm happy for the opportunity to get to know the horse. [Figure #2. - horse and figure face each other]

Hanna: It's at the moment of giving the apple. I'm not sure about the feeling, but I would like to get closer to the horse with the apple. [Figure #3. - horse and figure face each other within a designated space]

Laurie: The horse is taken over by some else. What I love most in the world is taken from me. This is the thing I love the best. [Figure #4. - trailer with a tiny crouched figure next to the horse's muzzle sticking out between the bars]

Sue: I'm sitting in the trailer. I want the horse to like me. I'm out of the picture, sitting there alone and I can't get the horse back. I can't make it like me. [Figure #5. - horse and dreamer with an apple sitting in the trailer; another figure standing to the left of the horse]

Stage III: The Dreamer's Response

Sue had made notes of the group's projections. She began by reiterating that it was "definitely a bad thing" that the horse could talk. Sue talked about her cat at home which she takes care of. The cat loves her and does not judge her as she fears the horse will. She acknowledges that she wants "horseback riding to be my thing", and she doesn't feel it can be, if someone else also rides.

Sue admits not feeling "secure enough". She's afraid that the horse will talk with others, that it has a mind of its own, but also that she feels that something is being stolen from her. The contradiction between the horse making up its own mind and the fear of it being stolen from her was not clarified.

When asked how these ideas relate to the circumstances of her current life, Sue replied that they are "very relevant". For example, when she starts to make friends with someone, she is afraid that they won't like her. Sue became teary, then added that she often starts things, but never gets as far as she wanted to go. She has to be the only one who can do what she does. I suggested that to be herself, just as she is, doesn't seem to mean anything to her. The group reassured Sue that she was "special". When I commented that Sue didn't seem to believe the group members' comments, Sue responded that she felt selfish for wanting to be the only one (who can do something). When I reflected that her uniqueness doesn't seem to be enough to make her feel special, Sue replied, "it's getting better, just the fact that I can talk about it" is an improvement.

Stage IV: Eliciting Context of Life Situation

This stage began with a question about the weekend (her dream was from Sunday night). Sue had gone down to the Old Port with her parents. She sounded quite genuine when she said she had had a good time. Group members' questions linked weekend events to the horseback riding in the dream. It turned out that a conversation took place on Saturday during which Laurie and Sue spoke about riding. When asked if Sue remembered how she felt during the talk, she replied "pretty jealous". What surprised her about the conversation was the realization that she missed riding horses. Sue considered this "a good thing because towards the end" (prior to hospitalization) she could no longer ride.

When asked about her contact with Hanna over the weekend, Sue said that maybe she was "being a bitch" or had wanted to get close to her. This led Sue to the statement that "maybe the horse was everyone in the group at some

point" except that she didn't remember Jody (who had left the dream group earlier) as being part of it.

Stage V: The Playback

The playback, as such, was briefly concluded. I suggested that the dream may have been addressing Sue's process of getting to know the others in the unit, one at a time, in a way that feels safe and puts her in control.

What was not included was the link to her disappointment about the horse talking and someone else taking over the horse's attention. This may have mirrored her fears about being compared to others, and as a consequence, being rejected and abandonned because she is not sufficiently special.

Post-Dream Follow-up

The following week Sue had no additional thoughts about the dream, but said she had spent time thinking about the issues identified in the dream and had discussed in individual therapy her feelings of jealousy and her tendency to compare herself to others. The dream work had made her more aware of the extent to which she is affected by these thoughts and feelings. In reference to her difficulty in being in contact with her feelings, Sue reflected, "I'm aware of things, but they're not quite on the surface; I don't realize things up front". I suggested that working with dreams can be a way to develop her awareness.

Discussion

The foregoing dream group was selected for discussion because it provides a good example of difficulties that can arise if certain parameters of group dream work are not taken into consideration. This example also demonstrates that the application of an integrated model of dream work and drawing can be beneficial for patients diagnosed with an eating disorder.

Necessary Considerations

The session presented above suggests the need to reconsider the application of this integrated model of dream work and drawing, particularly if it is to be offered to a group of hospitalized patients. Issues of membership, confidentiality, and ego functioning. as well as the role of the leader must be considered if the members are to experience working with their dreams as a way to develop a creative and supportive engagement with their inner lives.

Conducting this study with patients hospitalized for an eating disorder helped to answer some initial questions regarding the capacity of this clinical population to engage in dream work. However, while these patients remembered their dreams and seemed willing to explore them in a group context, this sample session illustrates some key issues inherent in dream work conducted with patients in the beginnning phase of treatment. For example, given the likelihood of developmental deficits, these patients will likely have difficutly in sorting out the personal significance of the group's projections.

In the dream work cited above, Sue's suggestion that she may have been bitchy to Hanna or had tried to get close to her the day before the dream was a compliant acceptance of the group's projections, rather than a real

connection of the day residue and the dream content. Had Sue, in fact, tried to get closer to Hanna? Had learning of Laurie's horseback riding made Sue envious ("jealous")? Had Laurie actively encroached on Sue's attempt to befriend Hanna, resulting in Sue "being a bitch"? Sue's response to other elements of the group's projections was more straightforward, but in this instance, it was clear that she could not stand back and think through what had gone on in her exchange with Hanna. The presence of both Hanna and Laurie in the dream group was most likely a contributing factor. Sue's need for acceptance, reflected in her associations to taking care of her cat, may override her capacity to be authentic, a not uncommon dynamic in this patient population.

Other considerations which may interfer with the dreamer's and the group's attempts to link associations and day residue bear directly on the particular context of this dream work. Patients are admitted to the unit with their consent, implying an agreement to participate in all activities. This means that they did not volunteer to work with their dreams as would those presented with this option at the end stage of treatment or in a non-clinical setting. One might agree that the psychiatric residents and social work students who participate in experiential seminars on working with dreams do not "volunteer" either, if the seminar is required. However, their membership in a training program would be a cheerful necessity in the pursuit of professional goals compared to the loss of autonomy due to illness and hospitalization. This suggests that the need for recovery is exchanged for participation in experiences over which the patient has no control. In becoming a patient, the individual is confined in a set structure with a fixed number of staff and patients. The dreamer's compliant relinquishing of a right to privacy may mean that dreams are one of the few unshared

experiences. This scenario is in contrast to the initiative which led to community based dream sharing as a way to gain self-understanding. Group members must be free to choose if dream work is to be experienced as a welcomed, self-enhancing activity.

Implicit in the notion of freely engaging in dream work and drawing is the premise that this choice represents a lowering of defenses, dream recall being the first indication of a lifting of repression. The group's associations and the drawing response further the opportunity to confront resistance. In fact, the drawing more readily confounds the attempt to conceal conflict and, therefore, facilitates the uncovering and working through of defensive structures (Landgarten, 1975). It is not difficult to appreciate that if the dreamer is not free to engage in dream work, resistance may become more entrenched .

In the case of ths study, the patients' lack of choice in joining the dream group was compounded by their loss of the art therapy group which preceded the work with dreams. As stated earlier, an art therapy group was conducted while waiting for the unit membership to stabilize. The move to dream work represented a narcissitic loss of the therapist's focus on each individual during art therapy. Instead, the therapist became a group "leader" who focused on the process, rather than on the individual patients. After the fifth sesion of dreamwork, the patients expressed their disinterest in continuing with dreams and preferred a return to the theme-oriented art therapy sessions in which each patient addressed her own issues each week.

The context of this turn of events is significant to the discussion of factors which may detract from a succcessful application of dream work and drawing. These factors include conflicts within the patient group or between patients and staff which may impact on the dream group.

In actuality, in a setting such as this in-patient unit, the "dream group" is a construct of the group leader, given that the same patients constitute the psychotherapy group, the occupational therapy group, the dietary group, and so on. Unlike dream groups in non-clinical settings which meet once a week, group members live together without benefit of extended separations for work or other self-selected activities. Unlike dream groups of family units who agree to share their dreams (Ullman and Zimmerman, 1979), these patients are not given the option.

The dreamer who shared a dream in the fifth meeting chose to sign out of the unit prior to the following group. Her departure was an abrupt response to a conflict with the staff and clearly disrupted the unit. During the sixth session, the remaining patients protested against further work with dreams, citing the repetitive nature of the process and a desire to return to art therapy. One patient stated that individual work was "more profitable", and the others agreed that they were more interested in addressing their own issues. They did not feel that working with someone else's dream was a way to be in touch with their own conflicts, nor did the attention they received when the group worked with their dream make up for the attention they gave to others.

It is significant that the protest was initiated by a bulimic patient (the first to share a dream) and seconded by another patient being treated for bulimia (the second to share a dream), suggesting an enactment of the purging behavior which is typical in this eating disorder. The evacuation of dream work implies that working with dreams was not so much engaged in or digested, as it was incorporated in a binge fashion. The psychodynamic focus of dream work and drawing within a unit based on a cognitive-behavioral approach may have contributed to this outcome. The fact that the dream

group leader was not a permanent member of the unit may also have invited the acting out of psychopathology in that potential repercussions may have been perceived as minimal compared to the targeting of a staff member.

These events underscore the low level of tolerance for frustration which precludes these patients' capacity to make full use of a structured model of dream work and drawing which requires each patient to focus on a target dream. They lack the ego strength necessary to pursue the preoccupations of another while delaying the gratification of having others contribute to the understanding of their own dream. Sue observed that by the fourth week when she shared her dream there was little interest or enthusiasm on the part of the group. The others disagreed, maintaining that the disinterest was present only as of the sixth week, yet the description of the session clearly indicates the group's ambivalent engagement. This may be said to have been personified by Jody, who excused herself to lie down. She and Sue were know to be very competitive with each other.

Anxious about their own worthiness, these patients tended to compare themselves, only to confirm that others were more adept or possessed qualities that were beyond their reach. Of the two group members who supported the end of dream work and had not yet shared a dream, Jody had been very enthusiastic at first, but reported that she had not remembered any dreams during the previous six weeks. The other patient, Angela, had refused the opportunity to work on a short dream which had some sexual content. All of these factors contributed to a climate which was not conducive to dream work.

Perhaps another major contribution to the patients' eventual refusal to continue with the dream work was the shift in my role from art therapist to dream group leader. The replacement of the art therapy group with dream

work necessitated a significant reorientation of my role. As is indicated in the description of the dream group, in addition to moving the process forward as is required, my role as leader included my participation in the process. This stands in contrast to the containing/observing/interpreting functions specific to conducting individual or group art therapy.

This difference in functioning is central to the hypothesis of the Ullman model which is designed to endorse the dreamer's role as ultimate authority on the meaning of his or her dream. All participants, including the dream group leader, are bound to respect the dreamer's responses to the group projections. In practice, regardless of the leader's conviction that her/his ideas are relevant to the dream, unless the dreamer acknowledges the projections as meaningful, the leader, and all participants, must discard their own ideas and work strictly with what the dreamer had identified as relevant. This contrasts with the therapeutic context in which the patient is expected to give due consideration to the possible meaningfulness of the therapist's observations and interpretations rather than ignoring outright what does not seem to fit.

In the context of this study, the most striking aspect of this shift in roles was the patients' experience of the therapist/leader. In participating and modeling the process, I became more active, perhaps too much so for this particular group. It is likely that wanting to return to art therapy implied a desire to return me to a less active, and in their view, more containing role in which my engagement would focus on each one of the patients and their work each art therapy group. It is possible that my obvious enthusiasm for the process and the dreams became something else with which they felt a need to compete.

Despite these complications, it does seem that Sue was able to benefit from the sharing of her dream to the extent that it enabled her to recognize more fully her feelings of inadequacy and to explore this in individual therapy. If dreams are often about unacknowledged feeling reponses, then working with them can be a useful tool for those whose relationship to this level of experience is underdeveloped. It seemed that working with her dream had helped Sue to bring forward what was below the surface of her waking awareness. What is less certain is whether this experience will contribute to the development of an on-going interest in dreams extending beyond the end of active treatment.

A potential modification in the application of this integrated model of dream work and drawing for use with more symptomatic patients (such as in this study) suggests itself in respect to the group leader's functioning. With more fragile patients it may be useful for the leader to actively provide ego support in the form of questions which address the dreamer's apparent uncertainty or vagueness (e.g. regarding Sue's friendly overtures or bitchiness). Consistent with the notion of the dreamer's control of the process, the leader's questions would be structuring, rather than interpretive, pointing out elements for the dreamer's consideration or clarification so that links between associations, day residue, and dream content can be clearly established for more effective integration. This type of structuring or questioning may also facilitate the group's projective play by suggesting different possibilities that build on the participants' associations. The shift to this mode of intervention may necessitate a rethinking of the dream group leader's role to that of an approximation of a therapist, rather than a dream group leader.

Application of the Drawing Response

As was mentioned above, the use of the drawing response varied with each session. This was a result of the observation that the most effective use of the drawings had not yet been identified. The initial thought had been to have the dreamer respond to each member's drawings as a prelude to Stage III (the dreamer's response to the group's verbal associations) without having any comments from the members about their drawings. In practice, it was not easy to identity the moment in the dream which was the subject of each response drawing. Also, to have only the dreamer's thoughts about the others' drawings meant that the dreamer was the only one to comment on her own image.

As a consequence, in working on the second dream. the group was instructed to identity the specific dream content selected for their drawing response. The dreamer was the last to share her image. It was thought that this structure would provide a freer atmosphere in which participants would not be hampered by the dreamer's acceptance/rejection of their projections. Rather than have the dreamer comment on the others' drawings, it was suggested that we look at the images arranged in the sequence of the dream before moving on to Stage III. This came about quite spontaneously as a result of the response drawings and was not repeated in any other session. Rather than impose a specific use of the drawings, it was decided to keep this part of the dream work open to different possibilities that might arise from the group's drawing responses to each dream.

With the third dream, described above, each member, including the dreamer, commented on her own image, and the dreamer did not respond verbally to any of the group's drawings. The following week (dream four) the dreamer was asked to comment on each drawing response after the group

member spoke about her own work. This approach seemed to make the most complete use of the visual material. Unfortunately, this proved to be the end of the dream group, so there was no other opportunity to repeat this last approach to the use of the drawing response.

In retrospect, it is obvious that the drawings provided an unexploited opportunity to get the group to verbalize their feelings about the issues represented in the dream. These included the difficulty in establishing a friendship, the need to be in control, and the fear of rejection represented in the relationship between talking and judgement. A more in depth review of the images would have permitted each patient to elaborate these issues and to explore the nature of her despair, as in figure #4 (Laurie), #5 (Sue) figure #1 (Margaret), the quality of hopefulness, as in figure #3 (Hanna), or the (possibly defensive) openness to the unexpected, as in figure #2 (Angela).

Sue's image is a succint portrait of the paradoxical trap which her need for control creates. The visual depiction of being cut off from what she most wants is mirrored in the self-representation of the stick figure which appears, at first glance, to be in the same space as the horse. On closer inspection, it becomes clear that this figure stands in its own space, facing the viewer rather than the horse. The use of colour in depicting her conscious representation of herself (seated) reflects the narcissistic need to stand out, to be noticed as someone special. It may be that this is accomplished by her hospitaliztion for anorexia, an extreme strategy for attention which cuts her off from the enjoyment of horseback riding.

Alternative Applications of the Drawing Response

In addition to the various applications of the drawing response described above, yet another approach suggestes itself. After the completion of Stage II (owning the dream) and drawing response, Stage III (the dreamer's response

to the group's associations) could begin with asking the dreamer which drawing says something to her, then asking the group member to specifiy which part of the dream she has focused on, Only then would the dreamer be asked to elaborate her response to the drawing. This 'image clarification' tests the correspondence between the member's image and the dreamer's projections, allowing each person the possibility of understanding something new or different through the projections of the other. Afterwards, each group member would clarify her own drawing, saying something about why she chose to focus on the particular element. The dreamer could then add any relevant responses to this additional material.

Another possibility would be to move the drawing response to the head of Stage II (after the sharing and clarification of the dream and before the group owns the dream). In this way, the members would not be influenced by the verbal play of the dream, by the emphasis which the discussion places on certain dream elements, or by peer pressure. This may be thought of as consonant with the restriction against the dreamer's associations prior to Stage II or III which facilitates freer exploration by the group. Furthermore, it may be that the drawings can become the basis for verbal associations, making the imaginal play anchored to the unconscious/affective aspects of the drawing response, rather than the more cognitive, secondary-process oriented verbal play. This would make it possible for the group to respond to each others drawings as part of Stage II, rather than something apart.

In the face of these considerations, what seems most certain is the need to test out these modifications in order to determine the kinds of contributions that a drawing response can make to this particular approach to group dream work.

Extending Dream Work Through Art Therapy

Unlike verbal projections and associations, a response drawing generates a lasting record of the members' thoughts and feelings about their own or someone else's dream. This image represents the dream elements which are most compelling for that individual and, therefore, can be said to reflect intrapsychic concerns. As such, it may be useful to return to the response drawings in order to identify the latent preoccupations. There are several ways in which this can be done.

For example, once each member has shared a dream, the following session can be devoted to a review of each participant's series of response drawings. The task, to identify any underlying recurrent issues, can be organzised around several questions. Does the member gravitate towards something similar in each of the dreams? What is the subject that connects the drawings? Is there an overriding affective theme? What elements in the series seem most pertinent to the member's current concerns? Reflecting on these questions can become the basis for a response drawing to a patient's own series. If it seems more appropriate, the member may chooose to explore one response drawing in particular, perhaps the one which corresponds to his or her own dream, and do a drawing which extends the thougths and feeling in that image.

Another option is to alternate between working with a dream one week and with the response drawings the following week. The opportunity to take a closer look at what was elicited in one's psyche, while attending to someone else's dream, mitigates against feelings of isolation and can contribute to an awareness of the mutual benefits implicit in this approach to group dream work.

The advantage of returning to the drawing response is that each patient is able to focus on the concerns which were stimulated by the target dream. The key dream elements which are the basis of the drawings, form a kind of response dream specific to the treatment context. The identified dream elements may be said to represent the development of the patient's intrapsychic vocabulary. As a mirror of these preconscious concerns, the patient can begin to recognize the nature of his or her conflictual issues. This process of generating representations of inner object relations with which the patient can identify parallels the nature of the projective play of group dream work and drawing. The attempt to bring meaning to someone else's dream is to draw on, as well as to develop, the metaphoric understanding of one's own life experience. This process is greatly enhanced when the group members share a clinical diagnosis.

The above modifications in the use of dream work and drawing may provide a model which can be better suited to patients in the beginning phase of treament. By grouping response drawings into identifiable themes, patients can reflect on the individual dynamics which they have in common with each other as members of the same diagnostic group. The alteration of group dream work and drawing can help patients to slowly build up their toleration for frustration without undue narcissistic strain.

Moving back and forth between psychodynamic interventions which make greater and lesser demands on the patients, relative to the individual's role in the group model, can contribute to a developing sense of competency which supports other therapeutic activities in the treatment plan. Perhaps this combination of "strain and support" in a group context may allow the application of dream work and drawings to other populations.

Summary

An art therapy approach was integrated with an established model of group dream work (Ullman, 1979; 1988; 1990) by including a drawing response as part of the projective exploration of the target dream. Imaging the dream provides an organization of the symbolic/emotional content which might not otherwise be accessed or even be apparent. This integrated model was thought to be a potentially beneficial intervention for patients who share a clinical diagnosis.

The explicitly projective nature of both the verbal and non-verbal elaboration of dream images serves two purposes. The dreamer's safety is ensured by the consensual distance of a projective response while, paradoxically, group members reveal something of their own psyches by virtue of their projective involvement in the target dream. The integration of the drawing response has much to offer in terms of extending the projective play of working with dreams. The collective images may be considered a window into the intrapsychic dynamics specific to individuals within a given population. However, the exact manner in which to process these drawings has yet to be determined and can provide the basis for other studies.

The application of this expanded model to patients diagnosed with an eating disorder addresses questions regarding the capacity for dream recall, the willingness to share dreams in a group, and the extent to which these patients are able to engage imaginally in dream work. From the sample of dream work conducted on an in-patient unit, it is clear that prospective participants must be free to decide whether they are motivated to work with their dreams. Modifications to the the application of the proposed model are suggested in order to allow more severely symptomatic patients the benefit of working with dreams and drawings.

It was hypothesized that this hybrid model of group dream work and drawing at the end stage of treatment for an eating disorder might stimulate the discharged patient to continue engaging with dreams beyond the clinical setting. While this question can not be answered, given that this study was conducted with patients at the beginning stage of treatment, there is support for the possibility of such an outcome. Having established that this integrated approach can be potentialy beneficial for those diagnosed with an eating disorder, it would be interesting to apply this approach to other populations as a tool for continued self growth beyond the clinical context. This would place dream work and art therapy in the realm of preventative measures.

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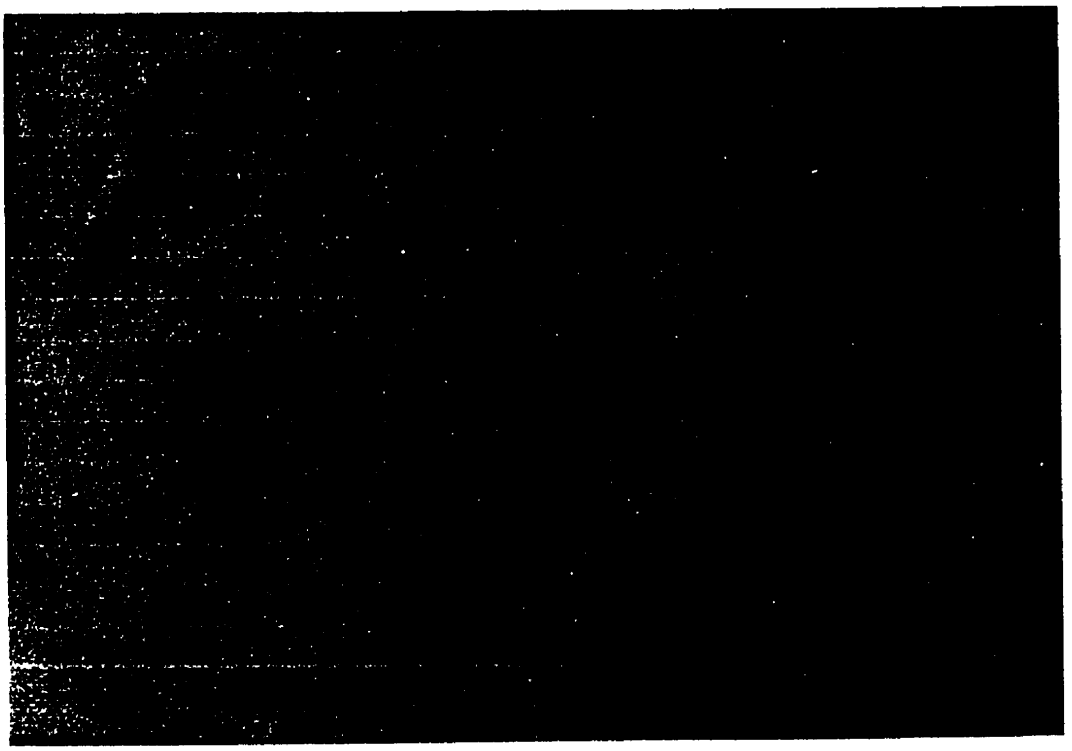

Figure #1

Margaret

Figure #2

Angela

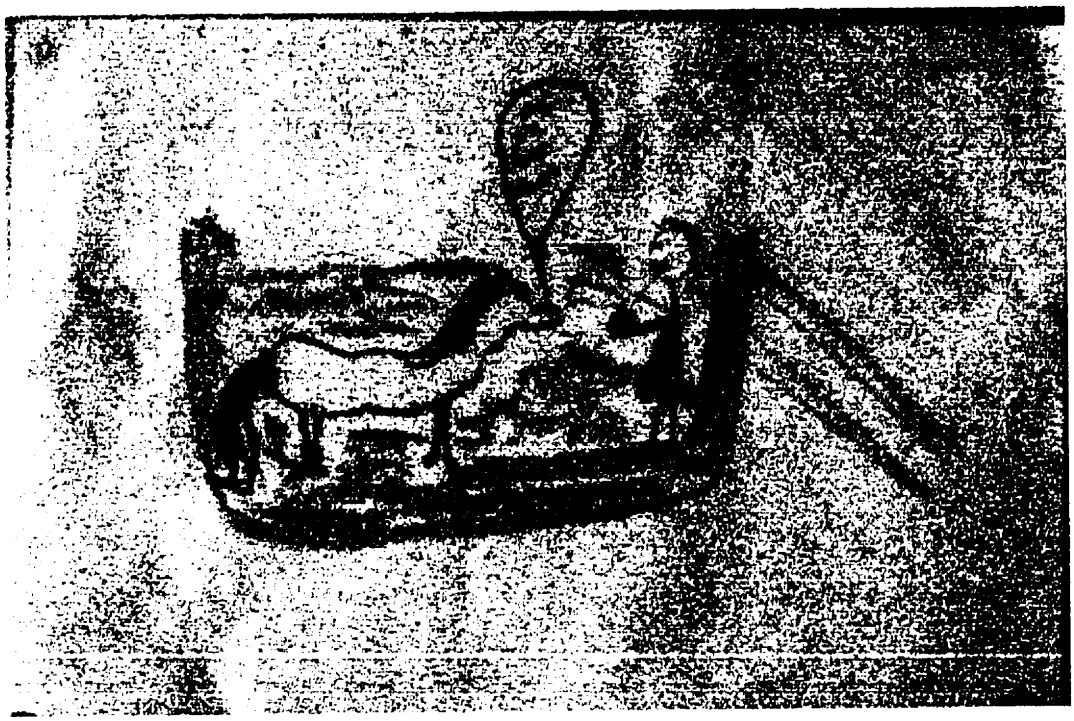

Figure #3

Hanna

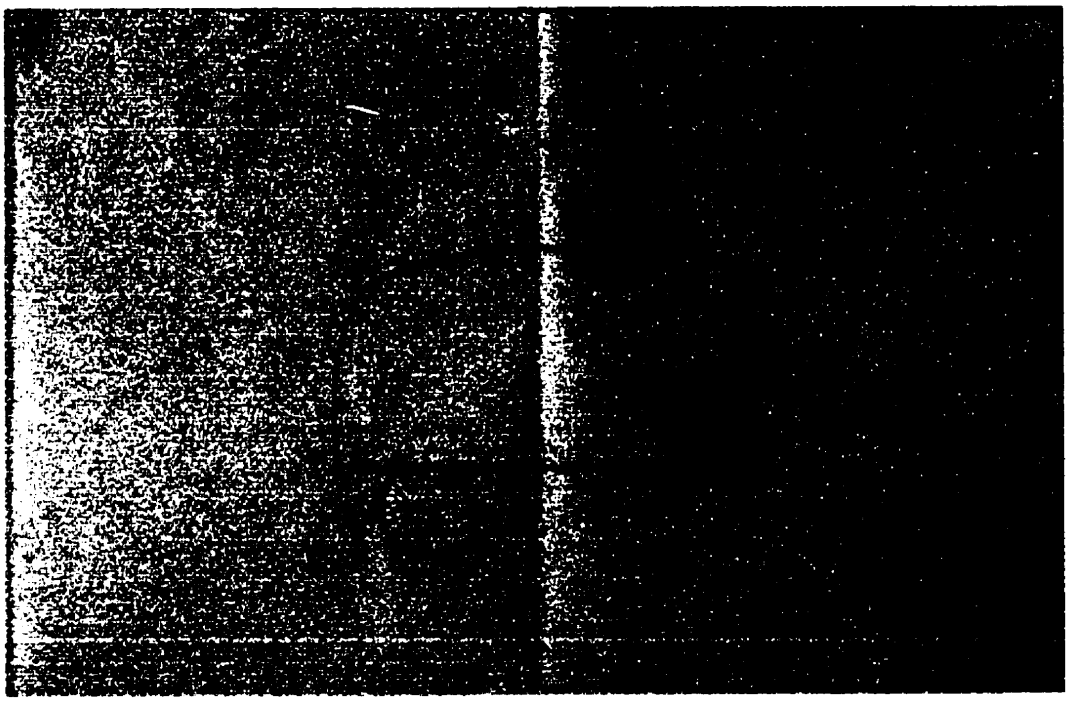

Figure #4

Laurie

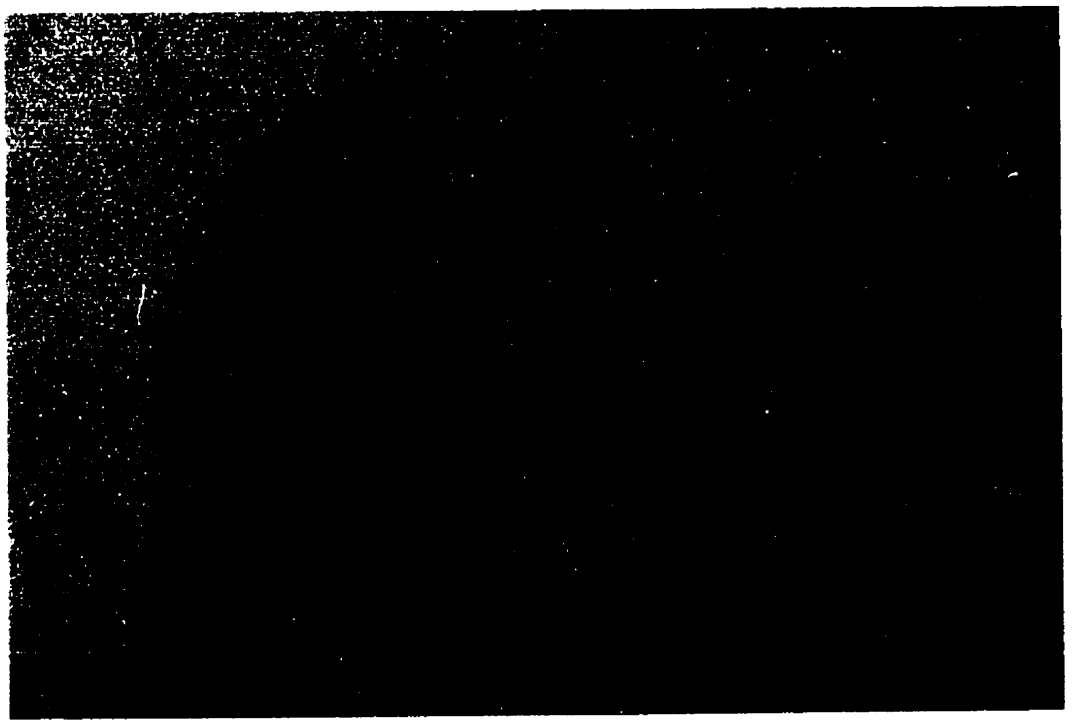

Figure #5

Sue