

Personal Artistic Representation of an Eating Disorder

Creating a Custom Scale to Assess Anorexia's Control Over the Mind

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Abstract

In this report, we present the case of a talented anorectic patient whose artistic expression of his anorexia gave us an exceptional insight into the pain he experienced. Based on his artwork, we designed an illustrated visual analogue scale (VAS) that allowed us to assess the control of the disease over his mind and thus the clinical progress from a psychotherapeutic point of view. By comparing the progression of the VAS with the Body Mass Index (BMI), we were able to identify the tipping point at which the patient regained control and provide targeted support to maintain it, perceived as very helpful by the patient. A VAS assessing anorexia's control over the mind is a simple and readily available tool that factors in the psychiatric background of the disease. It could be a good complement to the BMI as a clinical outcome parameter and should be further explored.

Keywords: Anorexia nervosa; eating disorder; art therapy; psychotherapy; visual analogue scale

Introduction

Anorexia nervosa is a severe eating disorder characterized by low body weight, an intense fear of gaining weight and is accompanied by subsequent, sometimes severe, endocrine disorders. The treatment is highly challenged by the ambivalence patients often present towards the treatment and by the control over the mind exercised by the disease [1].

This case report presents the situation of a gifted patient, whose artistic expression of his anorexia gave us a unique perspective of the suffering he endured. Inspired by his artwork, we created an illustrated visual analogue scale (VAS) to evaluate the control of the disease over his mind and thus the clinical progress from a psychotherapeutic point of view.

Case Presentation

The 28-year-old patient's illness began 2.5 years prior to admission. Likely triggered by a breakup with his girlfriend, he started eating mindfully and became vegan, causing a slow weight loss. A year later, while working on his thesis, he decreased his food intake and felt like he had to earn it by exercising. This led to a Body Mass Index (BMI) of 12.6 kg/m² and an increasing deconditioning, ultimately prompting an admission to a psychiatric hospital. There, he developed a refeeding syndrome and was transferred to the ICU before returning to the psychiatric ward for nutrition therapy. Later, he was admitted to our psychosomatic ward where he entered our inpatient therapy program with integrated complex treatment for

anorexia, including physio-, ergo- and psychotherapeutic interventions under medical and nursing supervision and care. The diet was set up with the help of the in-house nutritional counseling service.

On admission, he had a BMI of 14.43 kg/m². The clinical examination did not show any abnormalities beyond the cachectic nutritional state. The ECG did not show any relevant changes. A macrocytic hyperchromic anemia revealed in blood analysis was interpreted as part of the preexisting folic acid deficiency, which had already been adequately substituted during a previous hospitalization. The risk of refeeding was assessed as low, a step-by-step diet plan was drawn up by our nutritional counselors and regular blood analysis as well as clinical examinations were performed. A treatment agreement was drawn up with the patient and updated weekly.

During the first week, the patient showed signs of depression including anhedonia, lack of drive and changeable mood. He reported an obsessive fixation on food and weight, with the eating disorder giving him a sense of control and security. He had ambivalent feelings towards weight gain and found treatment both helpful and threatening. In the second week, the patient showed intense emotional reactions. The weight gain led to anger, sadness and helplessness. He felt trapped in a compulsive vicious cycle where he could enjoy meals only when he earned them through exercise. He compared himself to a junkie whose drug was

food and whose currency was starvation. After eating, he experienced an inner emptiness, which drove him to eat again in order to fill that void.

In the third week the patient lost weight, which he said he did through compensatory measures and not restriction, because eating was his only pleasure. His overall mood was poor. He reported sleeping problems, felt irritable, annoyed and angry. He tried unsuccessfully, to manage his anger through food. During one session, he was asked by his therapist to draw a personification of his anorexia as a means for further exploration. The result, the striking depiction displayed in figure 1, was discussed in the following session (see description).

An interesting interpretation point was the variability of the perceived size of the anorexia creeping from a tiny tick being a slight inconvenience with negligible impact on the patient's life, to a giant spider spinning its web around the patient, controlling every aspect of his life. It was this interpretation that inspired us to design an illustrated VAS (fig. 2A) to assess the control the anorexia had on the mind over the past week during the weekly updates of the treatment agreement (the first three weeks were assessed retrospectively). Following each assessment, the patient was asked how the anorexia's control could be reduced and how we could assist in the process. At first, the patient seemed a bit overwhelmed by the question, however, with some guidance from the therapist, the patient was soon able to identify strategies that would support recovery and ways in which our team could be of assistance. By the fourth week of hospitalization, the patient increasingly recognized that the anorexia had previously taken control and that she did not want him to feel better and get stronger. He described fear of responsibility and changes associated with adult life.

In the fifth week, the patient felt emotionally numb and like he had reached a dead end. He had not felt joy for a long time and realized that by trying to suppress negative emotions with the help of anorexia, he had suppressed emotions altogether. He now was trying to find a healthier way to deal with them.

At six weeks, the patient reported difficulty dealing with anger and frustration and longed for control and predictability in his life. The anorexia was identified as an embodiment of that longing. He recognized that the breakup with his girlfriend had shaken his "basic trust in life", but that he was now on the path to repairing it. In the seventh week, the patient tried to dialogue with his anorexia in the context of a chair exercise. The pleasure of eating was hence found to relate not to eating itself,

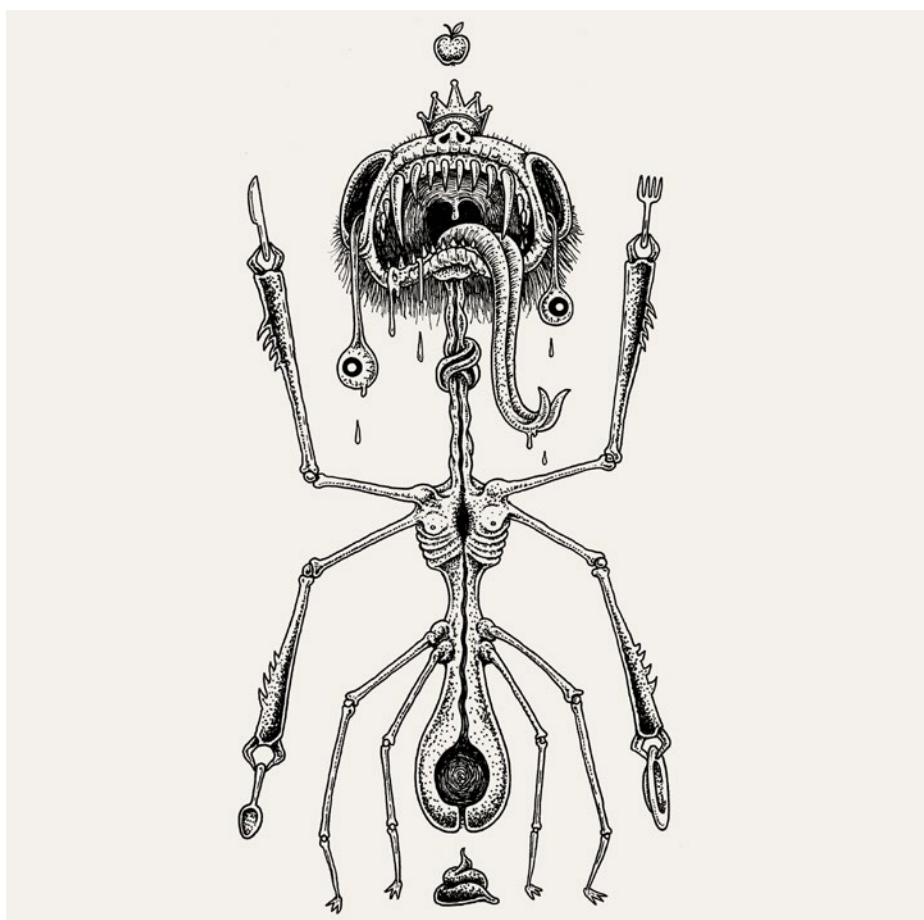


Figure 1: The Artwork and the Patient's Interpretations. Apple and feces are an allusion to the patient's own situation. At the lowest point of the anorexia, the patient only ate vegetables and fruit. The contrast between the small apple and the huge mouth emphasizes the discrepancy between the need and the intake. Like in the bible, the apple also embodies temptation and sin. Finally, the apple represents life as opposed to feces, which mean death and decomposition, to which anorexia ultimately leads. At the same time, defecation represents a relief in the sense of a release from the burdens and responsibilities of life.

The crown expresses the disease's claim to power over the psyche, but also the patient's power over the disease, since a crown can be taken off again. The crown as a political symbol reflects the struggle between him and his anorexia.

The head pointing upwards, striving for food, represents the desperate desire to eat. The huge mouth reflects the patient's insatiable hunger. The pointed teeth represent aggression and emotions perceived as negative. The forked tongue is an expression of the dichotomy between the healthy and the sick part of the psyche as well as a biblical reference to the serpent as a symbol of rebellion against the power of anorexia. Its forked tongue in turn is an expression of self-manipulation by excusing one's own needs. The eyes are withered and hang out, they are still there but barely have any function left. They look away from the food, gaze turned towards the ruin to which anorexia leads, but the white pupils blank it out. The large black eye sockets express the feeling of emptiness in the head and are at the same time a striking starvation-related physical change that can hardly be concealed. The bristly, unkempt hair is to be understood as an expression of the sick condition.

The knot in the overlong throat expresses physical discomfort; the suppressed feeling of hunger that sometimes feels like a lump or a knot in the throat. Furthermore, the knot prevents the passage of food and symbolizes the refusal to eat.

The outstanding ribs are another striking physical change of the starvation, the body consisting only of bones and skin. The black hole in the chest represents unsatisfied needs. The absence of a heart as a symbol for spiritual and physical life shows the feeling of inner emptiness that literally and symbolically absorbs and distorts one's own body.

The stomach is the most dominant organ of the entire digestive tract. Head and stomach are very far apart expressing an ongoing conflict between mind (head) and feelings/emotions (gut). The thick stomach wall is an expression of the subjective feeling of fullness despite the objective emptiness of the stomach; a kind of self-deception with which the contradictory goals of head and stomach are reconciled. The ambiguous representation of emptiness expresses the loss of one's own sense of the body.

With eight limbs, the anorexia resembles a tick that bites down and sucks out the lifeblood but it may also be understood as a spider spinning an invisible web in which one slowly becomes entangled/trapped. This contrast between the small tick and the big spider with the huge web embodies the mutability and thus the threatening nature of anorexia, as it can creep, almost unnoticed, from a small annoying nuisance to a life-threatening creature.

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but rather to the satisfaction that the anorexia allowed him to eat at all, which again made the patient realize his dependence on the anorexia's goodwill.

The weekly assessments with the VAS seemed to help the patient in his struggle for

control over the anorexia. While we initially expected the control of the anorexia to increase alongside with the weight gain, which indeed was the case during the first weeks of the patient's stay, from the fourth week on, the balance tipped. The patient realized that this

represented a turning point in the treatment, as if the anorexia was ready to accept little weight gains and started to surrender control to the patient (fig. 2B).

Overall, a positive course could be objectified with an overall weight gain of 1.7 kg over seven weeks. At the end of his stay, the patient's BMI was 15.02 kg/m².

Patient's Insight

The patient described the use of the VAS to assess the control of the anorexia on a regular base as very helpful. On the one hand, because it helped him focus on what the healthy part in him wanted and on the other hand, because it shifted the focus from the BMI towards the psychotherapeutic overcoming of the anorexia.

Discussion

The views and emotions the patient expressed in the psychotherapy sessions are largely reflected in the artwork and point to various psychopathological patterns described in different psychotherapeutic concepts.

From a psychoanalytic perspective, the description can be fitted into Freud's tripartite model [2] with the Id craving for food (huge mouth) held in check by a strong Superego (fearless, controlling, absolute) leaving little room for mediation by the Ego. From this perspective, the artwork may be considered as an embodied fusion of the patient's Superego with his Id. As such, it reflects the areas of tension between the two parts, e.g. the distance between head (controlling mind/superego) and stomach (emotions and needs/id). The artwork also hints at a considerable tension between what may be the death drive Thanatos (feces) and the life drive Eros (apple), the latter seeming slightly smaller than the first.

From a cognitive-behavioral perspective, several typical cognitive distortions can be objectified [3]. These include labelling (patient describing himself as a junkie, anorexia as queen), emotional reasoning (the eyes turned away from the food indicate an emotionally driven perception), mental filtering (focus on negative emotions in the artwork and during therapy), should-statements (I have to starve to earn food) and catastrophizing (the life-threatening nature of the disease is clearly emphasized over the current level of threat). The recurrent biblical reference in the artwork hints at an overgeneralization, while the difference in size of the apple and the mouth indicates a dichotomous thinking.

From an attachment theory perspective, the fact that anorexia gives the patient a feeling

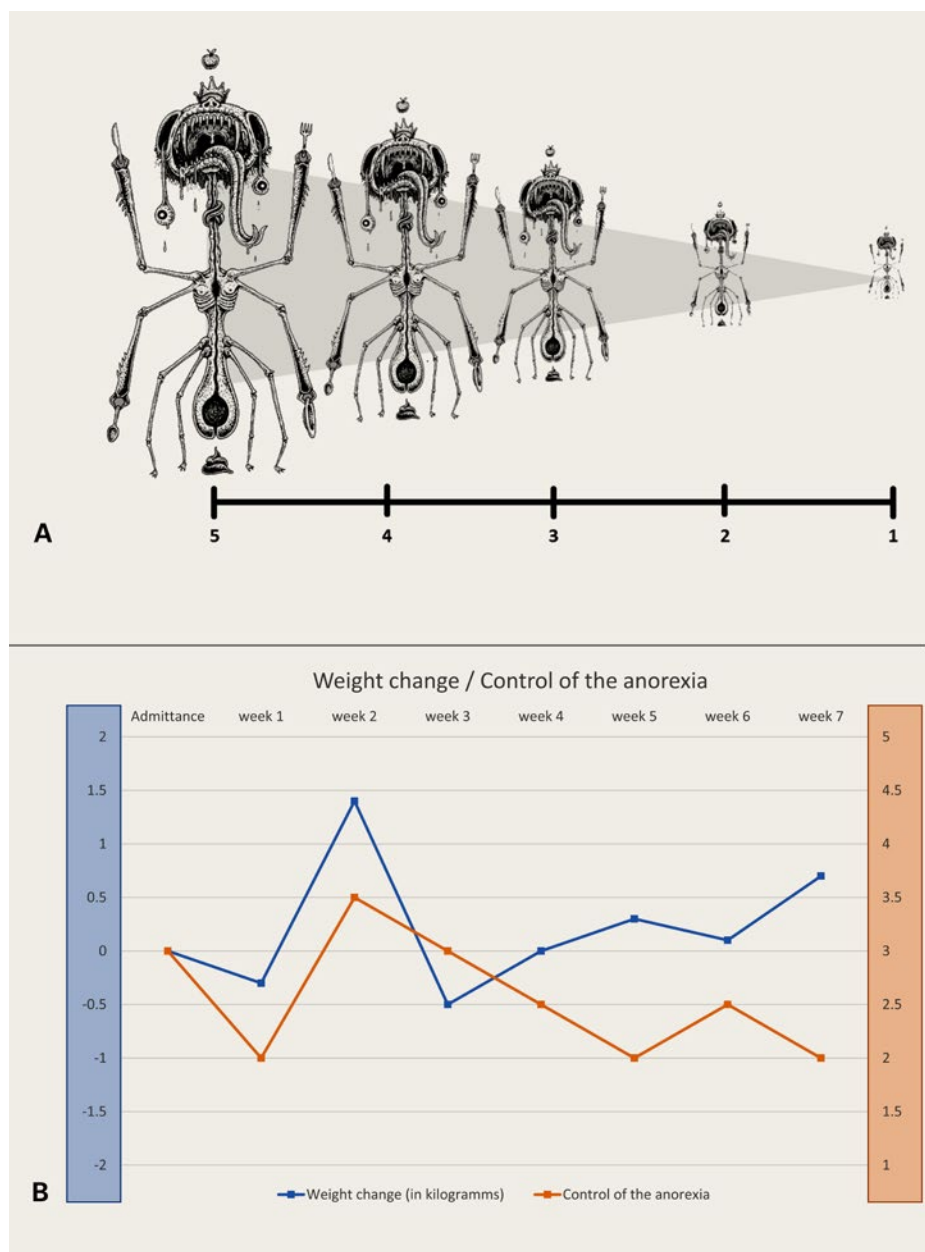


Figure 2: A) Visual Analogue Scale used to assess momentary Control Over the Mind. For the sake of clarity, we used five levels instead of the standard ten, with the option to assign intermediate levels. B) Weight changes vs control of the anorexia during the stay.

Week 1: The patient did not get enough to eat and therefore lost weight, was hungry at night and had difficulty recognizing this hunger. The overcoming of having to go to the nurses to get food did not fit into the role model of anorexia. He had done the physical exercise required by the anorexia during the day but had not received the reward (food) that he wanted. In the end, this contributed to the weakening of the anorexia.

Week 2: The patient was frightened by his weight gain, which strengthened the anorexia.

Week 3: The patient was disappointed by the weight loss, but it reconfirmed his need for treatment. The anorexia somewhat calmed, but was still on guard.

Week 4: The anorexia was still on guard, but the resistance of the patient was increasing.

Week 5: The patient was pleased with his weight gain, the anorexia that the weekly goal (500–1000 g) was not quite reached. The anorexia was not quite as triggered by weight gain anymore and settled for smaller goals.

Week 6: The patient was disappointed by the small weight gain, feeling like he was losing control.

Week 7: Weight gain motivated the patient in his fight for control.

of control, security and predictability that he lost after the separation from his previous girlfriend (which also heralds the onset of the eating disorder), may be an indication of an unresolved attachment pattern frequently found in anorexia patients [4].

Benefits of the Use of an Illustrated VAS

The BMI, often used as sole quantifiable clinical course parameter, does not take into account the cognitive changes achieved during treatment, which is unfortunate considering the psychiatric genesis of anorexia. A VAS for the assessment of the control of the anorexia over the patient presents a simple, readily available tool that could fill this gap and prove useful for therapy.

Art therapy can be helpful in the exploration of underlying thoughts and emotions by bypassing language-based defenses in patients with eating disorders [5]. By inviting the patient to draw his anorexia, we also meant to support the externalization of his eating disorder, and to highlight and address the existing cognitive distortions. The weekly assessment via VAS gave us a frame for repeated exposure to the drawing and the interpretations it contained, with the intention of further reinforcing the process of externalization and creating an egodystonia. The VAS itself exposes the sense of control conveyed by the anorexia as an actual loss of control by the patient. The intrinsic motivation to regain control can then be reinforced with motivational interviewing techniques (e.g., positive reinforcement of regained control according to VAS and evaluation of helpful interventions to further increase it) [6].

As reported by the patient, the VAS was helpful in shifting his focus from the difficult topic of weight towards other achievements, though this aspect should be considered carefully (see limitations).

While the VAS is commonly used in psychotherapy, it is usually scaled with numbers increasing from left to right. Our intention behind the inverted scale was to suggest a timeline (from left = past, to right = future) showing a desired course of decreasing control of the anorexia over time. This emphasizes that the goal of treatment is for the patient to regain control and reduce the anorexia's.

Limitations

Our approach has few, but relevant limitations. Firstly, although the patient described the use of the illustrated VAS as helpful, its real benefit remains unclear and should be tested in clinical trials. Secondly, this approach requires a certain ability of introspection, awareness of illness and abstraction from the patient, which

may not be given in every case. Thirdly, a recent study by Voswinkel et al suggests that externalization of anorexia is not perceived positively by all patients [7]. The receptivity to such an intervention should therefore be assessed carefully prior to the intervention. Fourthly, in our case, the therapists' expectations and emotions were not recorded during the course of therapy. Since they can certainly influence the results of the assessment in terms of possible countertransference and response bias, they should be taken into account in future use of such a VAS. Finally, while such a VAS may be a good add-on, the BMI should remain the primary clinical course parameter. Firstly, because patients with a strong anorectic voice may otherwise concentrate their efforts on psychotherapy to divert the therapist's focus from the weight and secondly, because the course of the BMI determines the need for medical interventions. It should also be noted that motivational interviewing techniques (from which our method is derived) showed no significant effect on the BMI according to literature, which again emphasizes that the VAS is only suitable as an add-on and not as a first-line therapy [8].

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Ethics Statement

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Conflict of Interest Statement

The authors have no potential conflict of interest to declare.

Author Contributions

NM and GF collected the clinical data. NM wrote the first draft of the paper. NB supervised the work. NB and GF corrected the paper several times during the drafting process. All authors approved the final version.

References

- Williams S, Reid M. Understanding the experience of ambivalence in anorexia nervosa: the maintainer's perspective. *Psychol Health*. 2010 Jun;25(5):551–67.
- Tarzan M, Ndrio M, Fakoya AO. An Introduction and Brief Overview of Psychoanalysis. *Cureus*. 2023 Sep;15(9):e45171.
- Abbott MM, Goodheart KL. Cognitive Behavioural Approaches for Treating Eating Disorders. In: Good-

heart KL, Clopton JR, Robert-McComb JJ, editors. *Eating disorders in Women and Children: Prevention, Stress Management, and Treatment*, Second Edition. Boca Raton, FL: CRC Press. p. 371–5.

4 Gander M, Sevecke K, Buchheim A. Eating disorders in adolescence: attachment issues from a developmental perspective. *Front Psychol*. 2015 Aug;6:1136.

5 Bucharová M, Malá A, Kantor J, Svobodová Z. Arts Therapies Interventions and Their Outcomes in the Treatment of Eating Disorders: Scoping Review Protocol. *Behav Sci (Basel)*. 2020 Dec;10(12):188.

6 Resnicow K, Gobat N, Naar S. Intensifying and igniting change talk in Motivational Interviewing: A theoretical and practical framework. *Eur Health Psychol*. 2015 Jan;17(3):102–10.

7 Voswinkel MM, Rijkers C, van Delden JJ, van Elburg AA. Externalizing your eating disorder: a qualitative interview study. *J Eat Disord*. 2021 Oct;9(1):128.

8 Fetahi E, Søgaard AS, Sjögren M. Estimating the Effect of Motivational Interventions in Patients with Eating Disorders: A Systematic Review and Meta-Analysis. *J Pers Med*. 2022 Apr;12(4):577.



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