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**The Two Faces of Anorexia: Front Stage and Backstage**

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in

The Department

of

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## **ABSTRACT**

### **The Two Faces of Anorexia: Front Stage and Backstage**

Synthia Tom

This research paper explores the use of drama therapy, integrated with concepts from Goffman's dramaturgical model, in the treatment of clients with anorexia. The goal of this study is to illustrate the way in which drama therapy is effective in drawing out the true self/backstage of clients with anorexia. Goffman's dramaturgical model, which is a self-representation model, describes self-representation in terms of a front stage and a backstage and that a person will act according to the situation while there are other things taking place backstage, yet are not revealed (as cited in Moghaddam, 1998). Hence, these concepts of a front stage and backstage also parallel the true self and false self of the client with anorexia and the aim of drama therapy in this study is to draw the true self out onto the front stage. Thus, the core section of this paper lies in the third chapter which focuses on the use of drama therapy interventions (with narrative therapy psychodramatic and cognitive behavioral therapy influences), as a therapeutic method in bringing a true self forwards. In accepting the anorexia as a negative force and problem to be dealt with then, I am working with the client towards a re-nurturing and re-feeding of her true self in terms of thinking, feeling and being.

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## **Chapter 1: Introduction and Purpose of Investigation:**

The purpose of this study is to demonstrate how drama therapy, integrated with Erving Goffman's dramaturgical model (as cited in Moghaddam, 1998), is beneficial to the treatment of clients with anorexia. Drama therapy is a psychodynamic approach that may incorporate other psychological tools in its structure. For instance, drama therapy may incorporate the use of behavioral and cognitive techniques since both of these are commonly used in treating clients with anorexia in terms of the treatment's psychological component. In addition, several authors have mentioned self-representation in the definition and treatment process of anorexia which is where the integration of Goffman's model of self-presentation becomes important (Bruch, 1973; Halvorson & Neuman, 1983; Johnson, 1991; Marx, 1994). Thus, in using a drama therapy treatment plan combined with concepts from Goffman's dramaturgical model, there is a strong potential for therapeutic healing by bringing out what I have termed as the backstage/true self of the client with anorexia.

Goffman's dramaturgical model of self-presentation presents the notion of a backstage and front stage in which the front stage is where one "performs" according to the situation and/or person she is facing, and the backstage is where many things may take place, but may never be revealed (as cited in Moghaddam, 1998). In Goffman's book, *The presentation of the self in everyday life*, Goffman (1959) states: "At one extreme, one finds that the performer can be fully taken in by his own act; he can be sincerely convinced that the impression of reality which he stages is the real reality" (p. 17). Hence, this concept of a person being fully taken in by his own act parallels the potential level that anorexics can achieve in the progression of the eating disorder. The

level to which I refer to is when the client begins to have increased distorted cognitions and distorted self-perceptions and is convinced that she really is fat when in reality, she is physically and mentally deteriorating. Therefore, in looking at anorexics, this notion of the front stage and the back stage in relation to self-representation exists quite prominently in terms of how the anorexic client presents herself as a kind of false self front stage and how her true self is hidden backstage hence, creating a front stage/false self performance and back stage/true self reality. As for what may fall under the category of a false self or true self will be explained further on in this chapter.

The use of drama therapy as an approach then creates the framework and method within which the process of drawing out the backstage/true self reality occurs thereby creating what I propose to be an effective way of treating clients with anorexia. Drama therapy is extremely flexible in terms of the tools it can provide in exploring the client's struggles and illuminating the backstage/true self. As Emunah (1994) asserts: "Within the world of make-believe, one can confront difficult situations, try out new options, prepare for real-life events-all without consequences" (p. 39). Drama therapy offers a world of make-believe full of projective techniques which include masks, figurines, puppets, stories, videos and theatre performances amongst many other possibilities through which the inner psyche can project upon. As a result, the psychopathology that exists behind the disguise of starvation starts to take form in the space and for some clients, the distance that the metaphor offers is perhaps a safer way of addressing their personal experiences.

In my own use of drama therapy, I have incorporated cognitive techniques, which has proven essential in working with clients with anorexia so as to challenge and later

replace the distorted cognitions with healthier and positive statements. Moreover, it has been from my experience in working with clients with anorexia that sometimes, the false self is so strong in wanting to keep the anorexia and in wanting to starve, that there is a large resistance to talking or even acknowledging that there is a problem. Thus, drama therapy is useful because it also provides possibilities in working non-verbally and indirectly by working through the metaphor. Hence, the work of the metaphor presents a symbolic world that mirrors the client's real world, offering a distanced way of working by addressing issues within the structure of a story, drawings, figurines or puppets. For people who want to work more directly, I use role playing and scene work amongst other tools, but I have also incorporated the use of working in the metaphor when it deemed suitable. Case examples will be given in Chapter 3 to demonstrate the use of drama therapy with the integration of backstage/true self and front stage/false self.

Another factor that is important to consider in this treatment process is the developmental process of adolescence because it is simply not an issue of having anorexia, but also the difficulties posed by the period of development in one's life. Adolescence, is a transitional stage when the adolescent struggles between trying to step away from being treated as a child, yet is not fully prepared for complete adulthood either. In other words, it is a process of individuation, and I use a combined definition of individuation here, integrating Carl Jung (1953, as cited in Frankel, 1998) and Peter Blo's (1967, as cited in Frankel, 1998) perspectives. Hence, in the process of individuation, the adolescent tries to shed family dependencies and detach from infantile object ties to become an individuated adult in society while trying to develop an individual personality as well.

In accordance with the individuation process are the cognitive changes that occur during adolescence: “Cognitive changes in adolescent thinking which may influence other domains, particularly the development of identity as well as one’s abilities to: think through hypotheses; think ahead; think about possibilities; think about thoughts; and think beyond limits” (Keating 1980, as cited in Boyd 2000). Hence, the cognitive changes in relation to the development of identity are particularly striking in the context of this study because of the destructive identity and image that adolescent girls with anorexia adopt while searching for their identity.

As the old aspects of a person’s life are being shed and new aspects are taking its place during the process of individuation, adolescents become sensitive to external images as well as to other people. As Harter (1990) states: “Defining who one is in relation to multiple others, determining what one will become, and discovering which one’s many selves is the ‘true self’ are the normative developmental tasks of this period” (p. 383). Thus, in relation to anorexia, a culture that is defined by thinness and perpetuates images of thinness, as being connected to beauty and success, holds a mirror up to adolescent girls to create a starving and empty identity as opposed to the happy self that anorexics think they may achieve in being thin.

In this journey towards finding an identity then, many adolescent girls are in a position of questioning what is considered right and normal and how they should be in the process of trying to “find themselves”. Therefore, some start to become self-conscious and very sensitive to statements concerning their bodies and appearance. In receiving remarks regarding their bodies, the feelings of vulnerability and insecurity are enough to push adolescent girls towards dieting as a way of achieving what they may

believe to be happiness by being thinner. Thus, in addition to providing a warm and empathetic space for these adolescent clients with anorexia, it is important that the therapist mirrors the client's feelings and reflect her thoughts back to her so as to help the client see and own her feelings and own her voice as opposed to taking on a "regurgitated" voice. This mirroring then helps strengthen their position in the world and their sense of self through the witnessing and validation of their feelings and personal story.

My hypothesis in this study is that an anorectic's true self/backstage can be given voice through the use of drama therapy and that by acknowledging the true self first, the cognitive and perceptual distortions associated with anorexia may be worked upon more effectively because the true self is accepted. In using Goffman's dramaturgical model (as cited in Moghaddam, 1998), I am not quite using an adaptation of the model, but rather emphasizing and focusing on certain parts of his model which are the front stage and the backstage and how they relate to the true self and false self. The position of the true self being hidden backstage and needing to be revealed and accepted in order for the client to work towards recovery by combating the problem, by changing the destructive cognitions and behaviors in favor of working on a healthier sense of self in terms of self-confidence and self-acceptance.

The clients with anorexia I work with are adolescents referred by doctors at a hospital in Montreal and these clients have been seen as inpatients and outpatients. As for case material, I rely primarily on the client's work and my notes, which I take within the sessions so that I may record the clients' exact words. The following chapters include

an overview of the current treatment for anorexia as well as the use of drama therapy and mention of further work that has been done using drama therapy as a treatment method.

In terms of the limitations of this study, the first is the population which is limited to adolescent girls with anorexia since there is a higher prevalence of this eating disorder in the female population than in the male population. Although there has also been research on anorexia associated with other disorders such as schizophrenia, borderline personality, obsessive-compulsive disorder, hysteria and affective disorder, I do not focus on them here because they fall under different diagnoses than simply looking at anorexia by itself. Thus, even if all these categorizations imply interesting features to the kind of front stage performance an anorexic might give if categorized with another disorder, it is not pertinent to this study. Furthermore, the same can be said of the biological perspective which is essential to understanding anorexia, but because I am dealing with a psychological intervention, my focus is on the psychological perspective.

Another limitation that I am aware of is that like most therapeutic relationships, the first phase in gaining trust can be extremely difficult and this can be even more difficult with anorexics' because their early relationships are often reported to be negative which in turn may cause difficulty in building trust in another dyadic intimate relationship (Bruch, 1973; Halvorson & Neuman, 1983; Johnson, 1991; Marx, 1994; Swift, 1991). Moreover the distorted cognitions of anorexics can be very difficult to change because their perceptual and cognitive reality is so far from what is true and from my experience with this population, they do keep a firm hold on this distorted perceptual view of their bodies. However, I am satisfied with the small, increments of improvement in the clients that I have seen. Another limitation of this study is that it cannot be

generalized to everyone as everyone is different in any case, and since, in addition, the vignettes provided here revolve mainly around one client. However, there may exist many characteristics that may be shared with other clients suffering from anorexia.

In terms of methodology, Hilde Bruch (1973) a leading authority figure on anorexia, emphasizes the importance of having the client as an active participant in the therapeutic journey. In my approach as a drama therapist, I believe that people can help themselves once they regain clarity on their situation and can recognize and acknowledge the obstacle that is placed before them. Thus, I want to act as a catalyst for helping the anorexic client to help herself and the main way through which I can accomplish that is to guide her in her journey of reuniting her with her true self. Thus, this will be a qualitative study and because of my choice to also utilize interpretations as part of the therapeutic process, my choice for methodology is hermeneutic phenomenology.

Hermeneutic phenomenology is an appropriate choice since literature on anorexia suggests that the best way to instigate treatment is to help the client discover her own thoughts and feelings (Bruch, 1973; Halvorson & Neuman, 1983; Strober, 1991; Swift, 1991). My use of interpretation, however, does not limit this process because hermeneutics still stays close to the client's experience as well. Furthermore, preconceptions and interpretations are part of what creates the possibilities for meanings in the client's life (Ray 1994). In hermeneutic phenomenology, the therapist must go beyond what is given directly and as Betensky (1987) states, what is also required is the: "...revealing the hidden aspects of man's being as phenomena accessible to consciousness and to conscious investigation" (p. 154). As for remaining close to the client's experience, I usually account for my own my assumptions by confirming with my

clients as to whether they agree or disagree with the assumptions I make and thus, together, themes and meanings emerge and are worked on through the therapeutic process.

Lastly, the operational definitions of the terminology used in this study. I use the terms clients with anorexia, anorectics and anorexics, which are terms used in the literature on eating disorders for describing clients diagnosed with anorexia nervosa. The terms true self and false self are loaded terms which encompass a variety meanings in relation to how clients describe their feelings as well as my interpretation of the terms. The term true self involves accepting and recognizing that they have a problem, an expression of emotions and other possible underlying issues that have been suppressed as part of an acceptance of working towards a healthy way of living.

The term false self, from my perspective, includes denial of having a problem, and this can come through a pleasant façade, in being completely compliant to the process and suppressing any underlying emotions by putting up a false front as well as by presenting a voice which is not the client's "own" voice, but a voice that the client has "regurgitated" from the doctor, father, mother or another person. As for an operational definition of self-representation, I refer to Goffman's dramaturgical model (as cited in Moghaddam, 1998), which suggests that one performs on the front stage according to the situation and/or person she is facing and that the happenings backstage may never be revealed. Thus, in looking at anorexics, the anorectic client presents her false self front stage to appease others and her true self is hidden backstage.

In looking at my area of study then, my bias is that in order to fix the body perception, to restructure the cognitive distortions, the client must first acknowledge the

true self. Otherwise, if the true self is not brought out and acknowledged, then it will be difficult to rectify the perceptual and the cognitive distortions. Thus, the model of bringing out what is going on backstage to the front stage is whereby the true self becomes spotlighted and acknowledged. I also follow the definition of success that Baker and Hornyak (1989) put forth, which is to help the client become aware of her inner world, to understand it, claim it and integrate it into her life. Thus, I propose how drama therapy can be useful in drawing out what is going on backstage to the forefront in a safe manner that would eventually have the client acknowledge and accept her feelings of her true self.

*Summary of each chapter briefly recaps the main points of the chapter:*

**Chapter 1: Introduction:**

This chapter briefly explains the purpose of the paper, its methodology, limitations, operational definitions as well as a brief preamble on the development of adolescence.

**Chapter 2: Literature Review:**

This covers the extensive literature on how anorexia nervosa has been defined in the past and present, the way that it has been dealt with in terms of treatment and in relation to the dramaturgical model concerning Goffman's model of the front stage and back stage.

**Chapter 3: Drama Therapy and Illuminating the Backstage**

Discussion of how drama therapy has been used with anorexic clients while intermittently integrating Goffman's concepts in the work as illustrated in vignettes.

**Chapter 4: Conclusions and Implications**

This chapter includes a discussion and reflection of the completed work in relation to the hypothesis as well as implications for further research to be done.

## **Chapter Two: Literature Review**

The definition of anorexia has evolved throughout history, first being linked to examples of pre-historical religious fastings, and then coming closer to today's definition in the early 19<sup>th</sup> century accounts by physicians who described anorexia as a lack of insight into the continuous weight loss as well as a refusal to eat (Blinder & Chao, 1994, Treasure, 1997). In terms of the current DSM-IV definition, the diagnosis of anorexia nervosa includes the following four criteria for diagnosis:

1. Refusal to maintain body weight over a minimal normal weight for age and height.
2. An intense fear of gaining weight or becoming fat, even though underweight.
3. A disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation or denial of the seriousness of the current low body weight.
4. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur  
(American Psychiatric Association 1994, pp. 544-545)

In order to fully understand the possible psychological patterns and underlying issues behind the fear of gaining weight and obsession of thinness, it is essential then to turn to important figures in the literature of anorexia. Thus, I begin with a significant contributor to the modern conceptualization of anorexia, Hilde Bruch.

Bruch (1988) decided to combine her early conceptions of anorexia by looking at them under a larger heading, such being the expression of a defected self-concept (as cited in Marx, 1994). Bruch's notion of the defected self-concept suggests that anorexics are playing a part in presenting themselves to others by being excessively compliant in their role. In support of Bruch's defected self-concept, the literature on anorexia also

describes people with anorexia as being people pleasers, having severe body and cognitive distortions about themselves as well as putting forth a false self for others (Dym, 1985; Halvorson & Neuman, 1983; Lask, 2000; Bruch as cited in Marx, 1994). Furthermore, literature on anorexia also indicates that anorexics usually share common personality characteristics. These personality characteristics show a history of perfect children who are often described as people pleasers, overachievers, perfectionists, well behaved, popular and conscientious (Bruch, as cited in Marx, 1994; Halvorson & Neuman, 1983; Lask, 2000). However, there are also negative psychological and phobic characteristics which eventually emerge in anorexia.

Halvorson & Neuman (1983) list these negative feelings, such as irritability, unsociable, helplessness, non-assertiveness, depression, obsessiveness and hysteria as part of the anorexic's predisposition should progression in the illness be furthered. In addition, anorexics are to exhibit what Lask (2000) describes as: "The restraint of negative, but not positive, emotions is commonly reported" (p. 66). Thus, the lack of assertiveness, yet the desire to please people amongst other personality characteristics, creates the false self with which the anorexics portray on the front stage.

Another contribution to the maintenance of the false self may be the observation made by Baker and Hornyak (1989) who state: "...many eating-disordered clients are cut off from their affective and cognitive internal experience" (p. 2). This can be in part due to the starvation effect on the ability to be aware on a cognitive level, but it may also be due to the extreme resistance and control on the client's part to not recognize the starvation as being a bad thing, but a good thing, hence, the lack of insight regarding the affective and cognitive internal experience. Therefore, the lack of recognition and

acceptance illustrates how the true self is literally starving and that the perpetuation of the anorexic state is essentially a manifestation of the true self starving. It is crucial then for the anorexic client to connect with her true self, to connect and accept what is being truly represented on the backstage, to bring about the person hidden inside and re-nurture her true self.

An additional author whose theories imply this notion of the front stage and back stage and who also has his own notion of the true self and false self is D.W. Winnicott. In regards to Bruch's defected self-concept, Marx (1994) makes an analogy of the anorexic's fake behavior to Winnicott's notions of the false self. In looking at Winnicott's theories on the true self and the false self then, the false self hides the true self and as Stevens (1998) states:

His (Winnicott), primary concern was with what he called 'false self disorder,' (essentially another term for 'schizoid disorder' ) whereby the 'true self' fails to develop and is supplanted by a 'false self' which strives desperately to cope, while putting on a pretence of dealing competently with life in the outer world. (p. 116)

Hence, both Bruch and D.W. Winnicott bring to surface the two faces of the anorexic client; the true self and the false self which also connects to the idea of the front stage and backstage.

In looking at Bruch's and Winnicott's theories, both authors' notions of the divided selves of anorexia draw on the developmental relationships in a child's early life interactions with the primary caregiver. According to Winnicott's theories, the true self emerges as a result of an attentive and caring mother, whereas a false self is created because of a mother's lack of caring and responsiveness to the child (Johnson, 1991).

Thus, in the development of the false self, the emphasis is on the weakness of an early relationship between the primary caregiver and his/her response to the child.

Similar to Winnicott, Bruch also addressed early family relationships as being essential in the development of the self. Bruch (1974) also believed that when the primary caregiver stopped responding appropriately to the child, then the child would become internally confused about how she should act to receive the appropriate response (as cited in Lask 2000). In describing psychological factors of anorexia, Lask states of Bruch's theory: "In Bruch's analysis this lack of emotional containment leads the child, in desperation, to be utterly compliant with what she perceives to be her mother's needs"(pp. 67-68). Hence, in relation to the front stage/false self and backstage/true self, the true self will emerge if early relationships are positive and responsive. However, as Swift (1991) observes, if the relationship is negative, then there will be deficits in the sense of self-identity and autonomy which is analogous to the backstage/false self.

Within the spectrum of literature on anorexia, separation-individuation is another theory which suggests a true self and a false self. Similar to Bruch's and Winnicott's theories, the negative caregiver-child dyad as a disruptive force in the nature of one's development is also associated with the separation-individuation model. However, separation-individuation takes a step further as Selvini-Palazzoli (1974) states: "...the anorexic does not experience her body as belonging to her. It is seen as a threat, which must be controlled" (as cited in Dym, 1985, p. 178). As suggested by Dym then, the failure to achieve both a healthy development and resolution of separation-individuation leads the anorexic to experience a number of negative emotions such as self-loathing and helplessness, which in turn, expresses the need for control over her body because the

anorexic feels so out of control at that stage. As a possible result of the self-loathing, the anorexic client might do whatever she can to avoid accepting her situation such as suppressing the true self, which then comes back to the notion of the false self on the front stage and the true self on the backstage.

Although my own work does not necessarily focus on the dyadic relationships that existed in the client's life, it is important to mention what has been said within the literature on anorexia in regards to theories that have been held with respect and worth. Moreover, what I do take from these theorists is the idea of the two parts of the self, the true self and the false self as well as the process of how to draw out the true self and have the clients release from the burdening suppression of negative feelings, thoughts and beliefs. As Browning (1985) states: "The false self is the person constructed and presented to the world in order to satisfy significant others" (p. 145). My initiative in therapy then is to bring back the true self and by integrating Goffman's dramaturgical model (as cited in Moghaddam, 1998), a potential deeper understanding may be reached on how to deal with the anorexic's distorted cognitions because of the connection that exists between an anorexic's portrayal of the false self and the client's self-representation via her performance on the front stage.

Prior to addressing my use of drama therapy in working with clients with anorexia, it is essential to explain the common treatment interventions for clients suffering from anorexia since I also incorporate some of these interventions in my own treatment plan. According to Bruch, effective treatment requires treatment on various levels of the anorexic client's life. Bruch (1982) stated: "The patient's nutrition must be improved, the tight involvement with the family needs to be resolved and the inner

confusion and misconceptions require clarification” (as cited in Treasure, 1997, p. 30).

This multidisciplinary treatment is important to follow through with because it tackles all potential problem areas in the client’s life by addressing the physical and mental health of the client. However, there is also an implication throughout the literature on anorexia which suggests that the primary source to successful treatment is the resolution of the cognitive inner processes and the acceptance of these inner processes (Bruch, 1973; Halvorson & Neuman, 1983; Strober, 1991; Swift, 1991). Thus, there exists the objective of recovering and correcting the cognitive structure of the anorexic mind and in terms of psychoanalytic and psychodynamic forms of treatment, Cognitive Behavioral Therapy (CBT) is the most commonly used treatment for clients with eating disorders.

The anorexic’s intensely distorted cognitive patterns and the inability to connect between one’s inner and outer reality alludes to the false self and the true self (Halvorson & Neuman, 1983; Magagna, 2000). In the past, there were difficulties with behavioral approaches since as part of its treatment, the focus was on weight gain and the difficulty being that anorexics intensely fear gaining weight (Dooley & Levendusky, 1985). Therefore, a current perspective on the treatment of eating disorders utilizes CBT which concentrates on making connections between the client’s cognitions and feelings and her environment and helping the client to change her unhelpful behaviors, thoughts and feelings into ones that help the client towards a path to health as opposed to one towards self-destruction (Christie, 2000; Gilbert, 2000).

Techniques used in CBT include self-monitoring, target setting, self-reward, scheduling pleasant events, exposure, relaxation and stress management, role-playing as well as several other cognitive techniques to counter the negative thoughts of the

anorexic client. The purpose of the techniques combined is to decrease the anxiety and fear, to find alternative and healthy ways of coping such as the awards and pleasant systems, as well as providing the clients with realistic targets in terms of the amount of time to achieve a certain weight.

In Bruch's work (1978), she mentions giving attention to identity issues, changing faulty self-perceptions, and improving interpersonal relationships in helping the anorexic client (as cited in Halvorson & Neuman, 1983). In addition, as quoted from Halvorson & Neuman, Bruch explains her psychotherapy treatment as: "A process during which erroneous assumptions and attitudes are recognized, defined and challenged so that they can be abandoned" ( p. 88)). Something that is central then to the helping process of the anorexic client is defining first what are the core beliefs for the client (Bruch, 1978, as cited in Halvorson & Neuman, 1983; Duker & Slade, 1988; Gilbert, 2000).

Core beliefs are the clients' longtime beliefs which are usually firmly rooted in the mind, and in relation to clients with eating disorders or other psychological disorders, these beliefs are usually negative and in relation to the person's self worth (Gilbert, 2000). Sometimes, to uncover these core beliefs is a process in itself because they may not come to the surface until later in the therapeutic process. The emergence of these core beliefs, however, can be very helpful because they can be the driving force behind the continuous negative thoughts. According to Gilbert, ways to access the core beliefs include a method of unpacking what the fear or anxiety means to the client, and to continuously ask the question of what the fear is about so as to uncover the true meanings of what it is to gain weight. As for the method of treatment, the way to reform the core

beliefs is similar to the way that the client must deal with her negative thoughts which is through cognitive interventions.

Self-monitoring is helpful as well because its purpose is for anorexic clients to write down categories of before, during and after eating or other times when they feel anxious and to record the negative thoughts which are triggered. Gilbert (2000) also suggests that the client keeps alternative and more positive categories so that there is a balance and the client does not forget about rewarding herself as a sign of accomplishment and encouragement. As for the cognitive techniques, they are used as a kind of reality testing in terms of questioning the statement's validity in real life, and then to find alternative, healthier ways of thinking. Cognitive techniques are carefully used on the therapist's part because there needs to be a balance of trying to help the client change her negative thoughts, but to also do it in a way that is not quick to indicate to the client that she is mistaken in the way she views her own life.

As mentioned previously, nutrition and family therapy are also assets on the road to recovery for the anorexic client and in fact, this multidisciplinary approach is offered at the hospital I work at. I work as a team in treating clients with anorexia and I do reiterate the significance of a multidisciplinary approach as an effective treatment plan. However, this multidisciplinary approach has never really discussed using a creative arts therapy in its approach, and thus, I propose how my work in drama therapy has proven useful in its contribution to treating clients with anorexia.

### **Chapter III: The Use of Drama Therapy in Illuminating the Backstage:**

In the book, Experiential Therapies for Eating Disorders, Baker and Hornyak (1989) state that within the treatment of eating disorders: "...something else is needed beyond a suitable theory and method, a something that has more to do with understanding and engaging with our clients on an experiential level" (p. 1). Amongst many of the creative arts therapies, drama therapy offers a multitude of possibilities ranging from story making and mask work to theatrical performances. Furthermore, since the population for this study concerns not only anorexics, but adolescents with anorexia, drama therapy is particularly constructive with adolescents because as proposed by Shaw (1981), creative undertakings are engaged in more often during adolescence thus providing them with a means of handling anxiety, working through feelings and exploring alternative solutions.

The structure of drama therapy encourages clients to create a space where they feel safe to engage in the process thereby feeling comfortable enough to gradually reveal the truth about themselves, or as in the case of this study, reveal the backstage/true self (Warren-Anderson & Grainger, 2000). In addition, the struggle to reveal the true self can be dramatically represented and accomplished through the medium of drama in shedding and integrating past roles and experimenting with new and possible future roles (Emunah, 1990). In terms of previous research on the use of drama therapy with anorexics, however, there has been little done hence the need for further research to be done because of the strong therapeutic potential that drama therapy can provide in treating anorexia.

Although the research that does exist and is pertinent to this study uses psychodrama as opposed to drama therapy as the treatment modality, the theories

supporting psychodrama as a treatment plan for anorexics can be equally supportive of the use of drama therapy. For instance, in discussing the use of psychodrama as an effective treatment, Hudgins (1989) affirms psychodrama's use of action-oriented methods as a way of eliciting the physical and mental experiences of the person's self, experiences of the self which may have been discarded previously. As a result, clients become more conscious of their experiences and internal feelings. Drama therapy accomplishes these same tasks as well by using action-oriented methods and providing an experiential awareness where the client becomes physically and mentally engaged as an actor does in a theatrical performance.

Another theme that is consistent between this study and the two studies using psychodrama is the notion of a suppressed true self. In her study, Hudgins (1989) alludes to the two sides of the anorexic client in her study and explains how psychodrama can help the anorexic client discard the false self in favor of what she calls a "real self". In Hudgins' psychodramatic process, she outlines stages in the therapeutic process in which the client learns to distinguish the experience between the real self and the false self. The ending stage of Hudgins' therapeutic process then becomes a shift for the client towards a real self.

Similar to the therapeutic process I achieve with clients, the client mentioned in Hudgins' article eventually becomes more engaged and accepts what she may have been suppressing inside. As Baker and Hornyak (1989) state: "Successful treatment involves helping these individuals to become aware of, understand, claim and integrate their inner world" (p. 2). However, given that the duration of my practicum is not as long as Hudgins therapeutic process, I cannot accomplish as much as Hudgins does with her

client, but I still have managed to begin the process of bringing forth the true self from the backstage in increments.

An additional study that reinforces the notion of the front stage/false self and backstage/true self is Levens' (1995) use of psychodrama with eating disorders. Levens' work with eating disorders strongly emphasizes the relationship between the anorectic's body and the ownership of her thoughts and emotions. In sharing this goal of revealing the true self in the use of psychodrama, Levens states: "Frequently, these clients' true, authentic self has been suppressed, denied or obliterated. It needs to be re-discovered so that they can say the words that were never said, experience the emotions never felt..." (pp. 165-166). This moving away of the false self as a true self unfolds is particularly difficult to do with clients with anorexia because of the difficulty of being in touch with their inner feelings as well as hiding deeper issues behind the surface problem with food (Dokter, 1995). However, the psychodramatic work that has been done by Levens is an illustration of trying to access the true self by helping the client access thoughts and emotions and having them own them as part of the healing process.

### **The First Phase in the Therapeutic Relationship:**

In beginning any therapeutic process, it is essential to form a strong and trusting therapeutic alliance with the client so as to set the foundations for further and deeper therapeutic work, particularly with clients with eating disorders since, as Baker and Hornyak (1989) state: "...eating-disordered clients are typically reluctant to engage with others when this engagement requires revealing their true selves"(p. 2). As mentioned previously, because anorexics' early relationships have often been said to be negative, the

therapeutic alliance between client and therapist may be difficult to achieve, but not impossible.

In building a strong therapeutic relationship, mirroring the client's feelings and actions is valuable as Hudgins (1989) states: "...the therapist may physically "mirror" the patient's nonverbal behavior, which tends to further strengthen the alliance. The therapeutic experience of empathically bonding with the therapist is developmentally necessary and reparative for anorectic patients"(p. 238). In reflecting back the client's own feelings to her, the client may feel more in touch with her inner feelings and may feel inclined to say more since she feels understood. Therefore, by providing an empathetic space where the client feels really attended to and listened to, helps in breaking down the resistance thereby enabling the client to become more open to working with the therapist.

The feeling of being heard and understood is especially significant to adolescents as Frankel (1998) observes:

What is therapeutic for adolescents is to be granted the opportunity to reveal themselves in the context of a genuine relationship. Adolescents are yearning to be made visible. Thus, they respond to the containment of a therapeutic vessel by giving expression to parts of the self that are typically held in abeyance (p. 4).

Thus, in the early stages of the therapeutic process, I refrain from making too many interpretations and negative statements about anorexia, especially if there is a strong attachment to the anorexia and a denial on the client's part in claiming she does not have a problem. It is important then for the client to feel like the therapist is on her side as Duker and Slade (1988) emphasize: "The first step is for the would-be helper to appreciate the sufferer's position fully....Helpers must also appreciate what the

consequences are for the anorexic in terms of her feelings, sensations and her understanding of herself..." (p. 140). Only once the trust between the client and therapist is established will the client become more open to therapeutic interventions such as interventions that focus on anorexia as a problem.

There is an emphasis then on the setting up of the therapeutic relationship and the therapeutic space so that the client with anorexia feels safe enough to release the negative affect such as anger and sadness that is immobilized in the false self and that needs to be expressed through the true self. For similar reasons regarding the therapeutic relationship, Goffman's notions are not always integrated into the work because the focus is really on what is helpful to the clients in their process as well as where they want to take the work. However, if I sense that the client is feeling more at ease in the process, I begin to integrate my interpretations so as to co-create with the client the meaning in the work. Hence, to reiterate my choice in using hermeneutics is because as a methodology, it acknowledges interpretations as valuable in constructing meaning in the therapeutic work with the client (Junge Borowsky, 1993).

Aside from being a period of building the therapeutic alliance, the first few sessions are also commonly a time of assessment. Assessment denotes a descriptive understanding of the client, her present perspective on life, her environmental situation and emotional state. Moreover, assessment provides the therapist with prescriptive information in terms of taking the information learned and applying it in the structure the therapeutic process in regards to providing techniques that may be helpful for the client.

### **Therapeutic Healing in The Use of Drama Therapy:**

An assessment tool that I frequently use in the first session is the head assessment, which I learned from Christine Novy (personal communication, September 03, 2001). The head assessment is a low risk technique in that it allows the client to express herself from a safe distance by metaphorically projecting her thoughts in an outline of a head through images or characters (see Figure 1). Thus, the head assessment indicates what is important for her at the time and how she perceives and understands her world at this stage in her life. As seen in Figure 1, being skinny illustrates the client's anorectic thinking since the client who produced this head assessment was an inpatient hospitalized for anorexia. In addition, the verbal exchange that occurs concerning the head assessment as well as a discussion on why she thinks she is in therapy begins to unveil some of the client's self-representation, thus giving signs of either a true self or false self.

In the beginning stage of the process, signs of a false self/front stage can be visible from the client's self-representation in the first few sessions and this is sometimes due to the fact that therapy may be part of the treatment plan and not always because the clients asked to receive therapy. In a situation where the therapy is prescribed, it is not unusual to have clients sometimes denying having an eating disorder or hiding behind the use of medical terms to describe their state such as not consuming enough calories for the amount they burn. However, what becomes evident in the therapeutic process is the struggle between the true self and the false self taking precedence on the front stage. Sometimes, it will seem as though the true self is becoming more present, but the false self is still lurking close by with a strong influence over the client. Thus, if there is the acknowledgement that anorexia is problematic, it is essential to follow up immediately

Figure 1: The Head Assessment



with a reinforcement of anorexia as a negative force so as to give more weight to the true self.

To resume then with the assessment period, I use tools which will provide me with a greater understanding of the client's beliefs and values so as to understand her more fully. The learning of the client's perspective helps in creating an effective therapy by assisting in having the client feel as though she is being truly seen for what she is (Emunah, 1994). Additionally, as sessions progress, I as the therapist begin to get a feel of the underlying issues which sometimes are very clear and close to the surface hence, allowing me to guide the client while staying close to her own experience. In doing so, I usually ask the client if she has a better idea on what she would like to work on in the therapy so as to re-focus the goals of the work. Although the client may be uncertain about what she wants to work on, common themes emerge in the work and with anorexia, it can range from having a low self-esteem to finding ways to cope with the stresses that may have caused her to turn to starvation originally as a way of suppressing emotional distress (Treasure, 1997). However, these themes only emerge through the work gradually, hence creating an open into the backstage/true self.

### **Externalizing the Internal:**

In accessing the true self, externalization techniques are very useful because they create distance between the client and the problem. Within a general context, clients who come to therapy may often feel that they are the problem thus, placing a lot of burden on them in terms of guilt and shame. In feeling they are horrible and that they are to blame, they are continuously feeding the negative thought process which makes it difficult then for them to see that they are anything else but a problem. Nevertheless, through the use

of distance in dealing with the problem, there is the process of separation from the action, or the problem in this case and then reflection upon the problem (Landy, 1996). Thus, dramatic distance provides clients with a different perspective and is useful in stimulating new ways of success and coping by being able to see the problem with a clearer perspective.

A contribution from the narrative therapy perspective that is poignant to this work is the aspect which focuses on finding an alternative story to the problem dominated story. Through questions of externalization, it distances the problem from the person and promotes the existence of the self as a separate identity, an identity that can exist without the problem. As Hepworth (1999) comments: "This creates the possibilities for a space to exist between anorexia nervosa as a thing that can be acted on and resisted, rather than being understood as an integral part of herself, and the definition of herself through psychopathology" (p. 114). As a result, there is a lifting of some of the burden that a client may feel believing and feeling that she is the problem.

This narrative therapy exercise, externalizing the problem, is a series of questions that encompasses different ways of perceiving and understanding the problem (as cited in Combs & Freedman, 1996). The questions require clients to think of a negative trait, emotion or quality that they or other people in their life think they have too much of. The questions are then divided into two sections with the first section focusing on the client as the problem. In the second part comes the externalization and after turning the trait into a noun, the questions map the problem's affect on the client's life as well as the influence the client has had on preventing the problem hence developing the alternative story (Epston & White, 1990). The separation creates two sides, the problem and the self and

thus paralleling the shedding of the false self in favor of a true self, in terms of acknowledging the self that exists and that can help in reworking the relationship with the problem by discussing other possibilities in dealing with this problem.

Another externalization exercise useful in working with clients with anorexia is a technique called negative messages. The client begins by outlining her body on a large piece of paper or she may do a miniaturized replication of herself if she feels uncomfortable being outlined. The client is then asked to fill the drawn body with negative messages that she has heard or believes that others may think of her during the course of her life indicating the person or persons that the message had come from and the emotions she felt as a result of that message (Dayton, 1990). After sharing the messages, I then ask the client to pick one of the messages that has affected her the most and sometimes, it may be more than one message.

The possibilities that derive from the exercise are varied. Letter writing or scene work may be used in which the client confronts the person who made the statement to them or in the case of a group, a physical sculpture symbolizing words or emotions associated with the message are helpful as well in releasing emotions. The enactment is especially powerful because by confronting the person, portrayed by someone or something else in the scene work, the client is confronting some of her own beliefs and thoughts by acknowledging she was affected by those messages and challenging her core beliefs by responding back in support of herself

An externalization exercise I use quite often in working with anorexic clients is the externalization and creation of a voice character otherwise known as what I entitled as the voice technique. From my experience in working with clients with anorexia, a theme

that often emerges is the presence of a voice. The presence of the voice has been said to cause the client excessive guilt by chiding or yelling at the client for eating and reminding her constantly that she needs to lose weight hence feeding the position of the false self by persistently distorting the client's cognitions and self-perception. Therefore, similar to the narrative therapy questions, the purpose of externalizing the character is to give the client a different perspective on the voice. Essentially, the voice belongs to the anorexia which is the false self because the anorexia perpetuates the denial of having a health problem.

In externalizing the voice, the first step for the client is to think of her negative voice and to imagine the possibility of producing her voice into a character. To create the character, I ask her to begin thinking about this character in terms of shape, color, size, texture and height. After the client has created a picture in her head, I ask her to produce the character using the materials available. The second step requires the client to think of questions she would like to ask this character and to then write these questions down after she has completed the character. In the third step, I ask the client simple and straightforward questions about the character and his/her environment in order to build a richer context for this character to exist, hence a beginning step in bringing the character alive. The third step is a stepping-stone into the embodiment of the character which is played by the client since she knows the character best. In continually trying to uncover the true self, I ask questions that both the client and I have regarding the active role of the voice in the client's life so as to sift through deeper thought processes.

This voice exercise is successful in its process of externalization through which the internal feelings and thoughts concerning the problem are externalized into a concrete

and tangible object that the clients can see and touch, thus physically separating the problem from the client. As for the role play, distance between the client and the character is still in effect since the client is not playing herself, but a made-up character. In preparation then for the client to embody the character, I ask the client to think of how this character moves, to take on the physical posture of the character as well as the voice of this character. In answering the questions as the character, I often encourage the client to be spontaneous in her answers since some of the essential qualities of a spontaneous act are an openness of mind and a freshness of approach which is helpful in leading the client to discover new feelings and thoughts in regards to her situation (Blatner, 1988). In addition, in playing the interviewer and questioning the character, I slip in some of my own interpretations, challenging the voice's "good" intentions to help keep the client "healthy". Thus, in focusing on the voice as a negative force, I start to un-package some of the surface issues concerning food to uncover underlying emotions and difficulties which helps in bringing out the true self.

An example of externalizing the voice can be demonstrated through the framework of another exercise which I entitled the map exercise. The map exercise is a map of the client's journey indicating events prior to the client's dieting up to her present situation while including what her most significant events were. The purpose of the map is to meet the potential metaphorical and/or human characters who have been part of her journey. These characters may be people who she has unfinished business with or they may embody feelings such as the client's anxiety or fear that have encouraged the anorexia to grow. In meeting these people there is a confrontation with the past and a

mending of the past in terms of bringing closure for the client which then allows for the creation of new future paths and possibilities to be paved in hope for a better future.

In regards to the negative voice, the map also traces the development of the voice and how its' force grew in the progression of the client's journey. In this vignette, Betty is a 15 year old girl who I had been seeing since November twice a week. Betty wrote out her map, explained each situation and mentioned that the presence of the voice was very tiny to begin with (see Figure 2). As Betty went through the map, the voice became stronger and more present as Betty's determination did to a path of strict dieting and regime. In looking back on her summer prior to the anorexia developing, Betty recognized that she often made an excuse to play soccer everyday by telling herself she needed to practice a lot so she did not let her team down hence bringing meaning to her own way of how the voice developed (personal communication, January 10, 2002).

The progression of the voice grew as Betty explained how she thought her doctors had been exaggerating about her weight loss being a problem and said she was in denial at the time, hence establishing the false self on the front stage and she still did not believe she had a problem when the doctors had said they would hospitalize her (personal communication, January 10, 2002). However, when she was hospitalized, Betty conceded to becoming more aware of her negative voice because she was alone quite often. In line with the denial, Betty also told herself that she had to eat so that she could get out of the hospital and return to losing weight once again supporting the position of the false self.

As for Betty's externalization of the voice, she created a mask with a division in the face in terms of color with a light side and a dark side (see Figure 3). She named the

Figure 2: Betty's Life Map

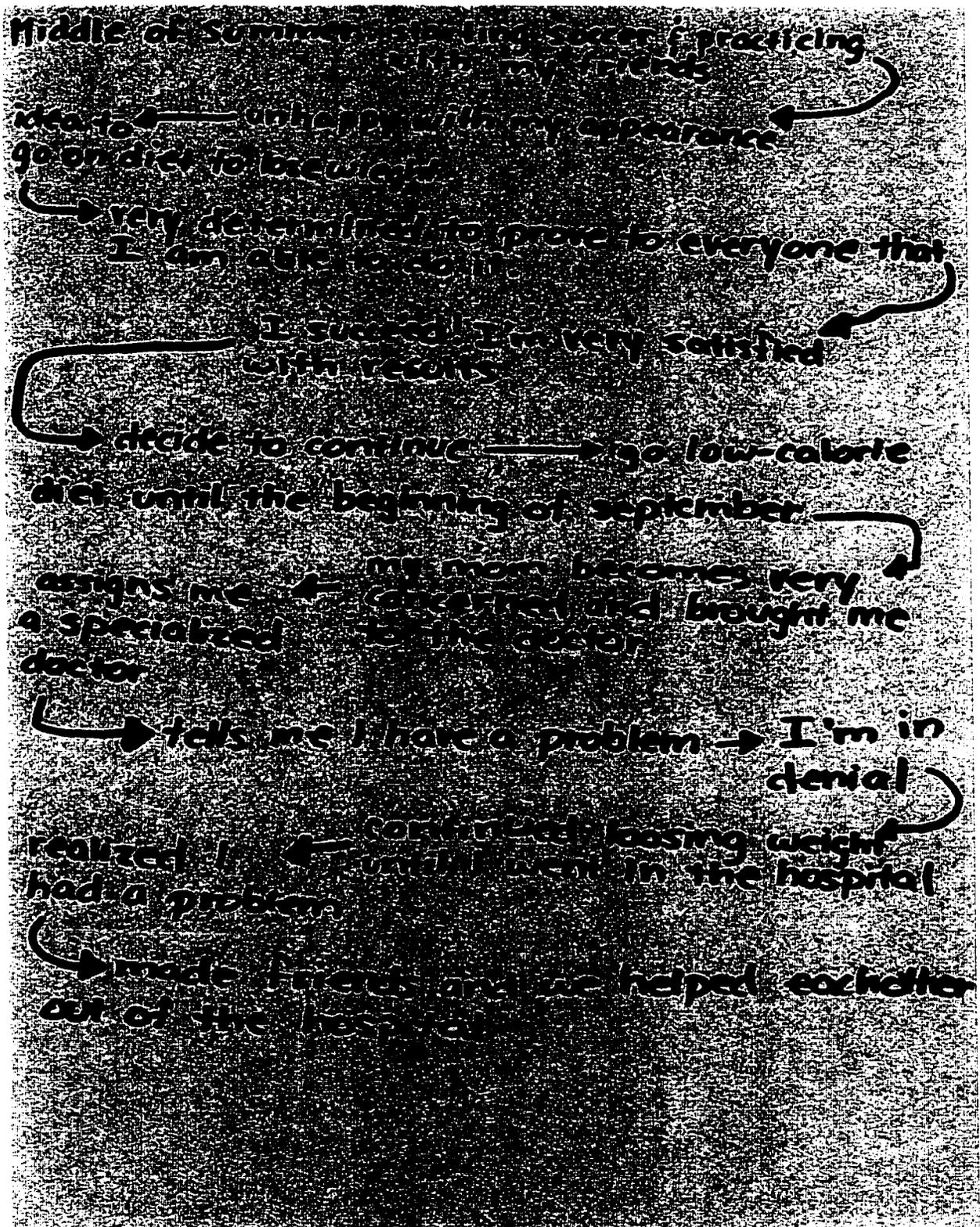
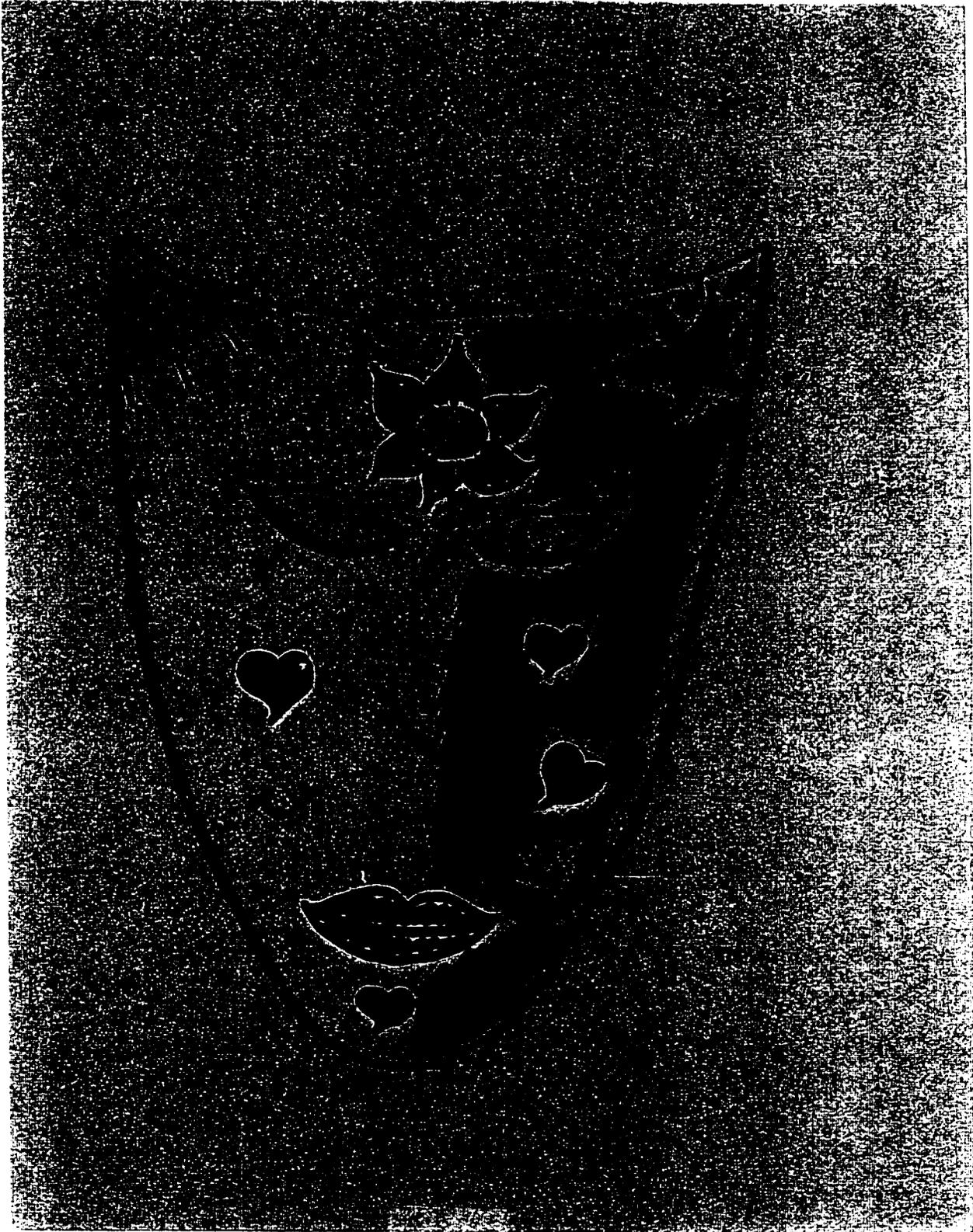


Figure 3: Betty's Mask: The Dark Side



dark side the shadow, also known as her negative voice, and said that in her present situation, the shadow has a bigger portion of the mask. As for the light side of the mask, Betty named it the guide. The guide and the shadow are two terms that had come up in conversations and she thought these terms fit the two parts of her mask. As for the mask itself, it provided Betty with some distance in seeing essentially herself and was extremely meaningful in unmasking the self that has been repressed by the client.

The embodiment of the voice came through the scene work in which I asked Betty to do a scene where the old Betty existed. Instead of using the mask, Betty wanted to use finger puppets instead to represent the shadow (voice) and the guide. In the scenes that Betty chose where the shadow/voice was small, the shadow kept telling her not to eat the junk food while her guide, her true self was telling herself that it was alright to eat the junk food. Betty said that she did eat the cookie and the ice cream, but added that it did not matter in any case because the shadow won in the end anyways by causing her to feel guilt for having given in (personal communication, January 20, 2002). In regards to the strength of the shadow, Frankel (1998) states: "The encounter with the shadow brings us face-to-face with our potential to act destructively toward ourselves and others" (p. 138). From enacting these early scenes of her old self then, it became clear that the shadow has quite a hold on her because she could not stay with the idea that at one time in her life, she told herself it was alright for her to eat junk food hence, making it difficult to see the potential light of the guide (true self/backstage).

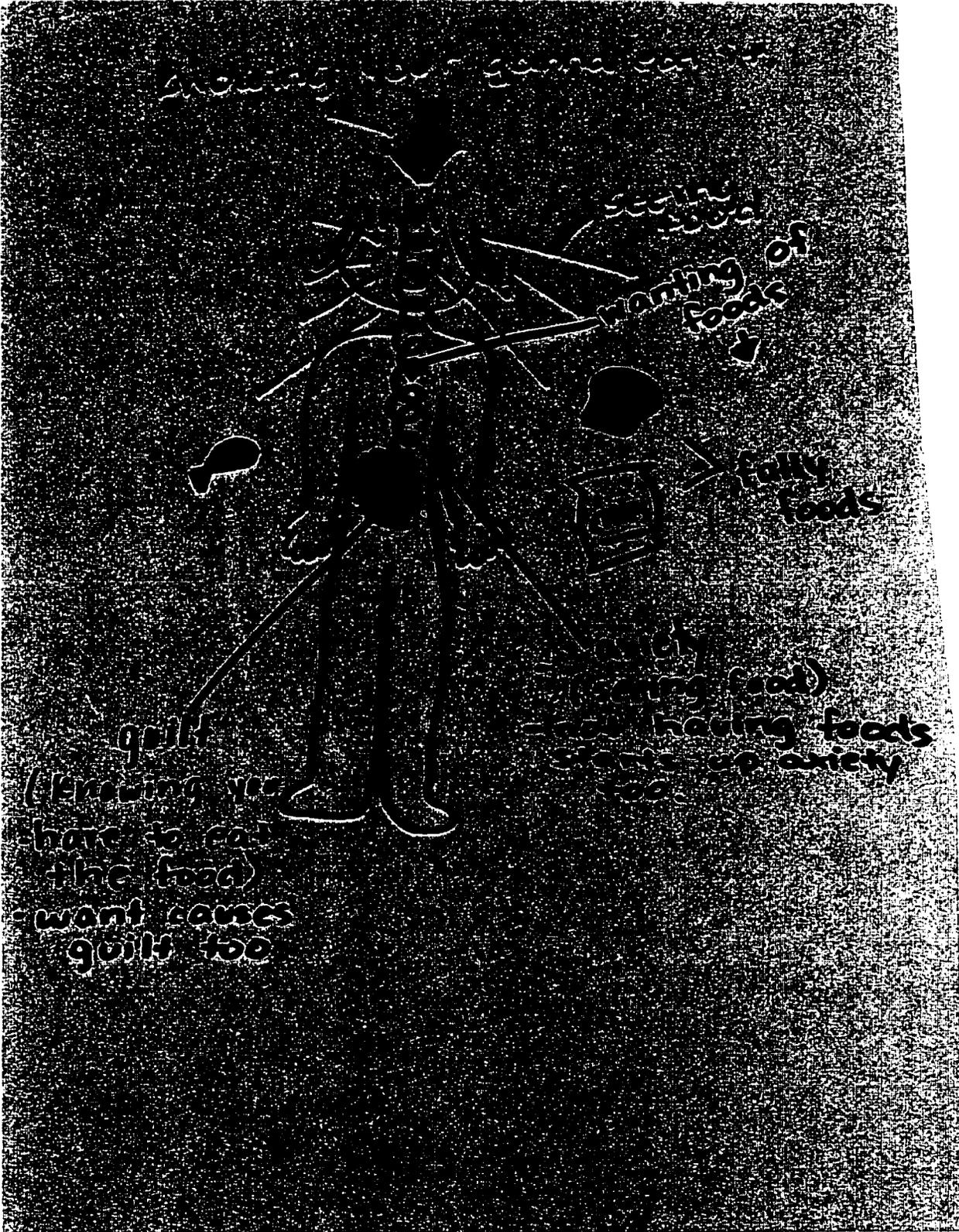
At the middle point of the therapy process, I feel it necessary to bring in cognitive and behavioral techniques into the therapeutic process as a way of reality testing in terms of testing how realistic her beliefs are. I also started using more cognitive techniques

because the therapeutic alliance was strong enough to withhold confronting the false self and beliefs that the client thought to be true. Moreover, I often told Betty if she was not comfortable answering the questions, she did not have to. For Betty, there was some insight in terms of seeing a bit of the true self and wanting to change the problem even though there was still a strong presence of the false self. Thus, the challenging of cognitive thoughts furthers the process towards the true self by discussing whether the eating disorder was actually bringing her happiness or what it does contribute to her life and if it actually succeeds in doing so. Betty said that being thinner would mean being happier however when I asked her if she was happy now, she said she was satisfied, but after a pause, she said that being satisfied did not necessarily mean that she was happy yet she still was not ready to gain weight (personal communication, February 05, 2002).

To further understand the anorectic's fear and anxiety, I used the exercise, the body expert which was useful in deconstructing the mechanism of the anxiety manifested while allowing the client to learn how to rely on herself to solve her own difficulties. The instructions are as follows, the client is to draw an outline of her body and is informed that there is some anxiety in this body, and the doctors have tried to help, but they did not know how to cure the anxiety. The client is told that she is the expert and as the expert, she can look in the body and can see what is wrong in the body in the form of an image. The client is then to produce the image, explain what she thinks is wrong and what are the possible solutions in lowering the anxiety (D. Lapinski, personal communication, February 22, 2002).

This exercise was done with Betty and her drawing really indicated the manifestation of the anxiety (see Figure 4). She explained that in seeing the food and

Figure 4: Betty's design from The Body Expert



wanting the food, her anxiety would start and as illustrated in her drawing, the anxiety would spiral downwards to the guilt built up in her stomach (personal communication, February 28, 2002). An interesting feature of this picture is the way in which it was drawn with a line running through her body, but also over her eyes and mouth suggesting a symbolic silencing of emotional expression and insight into the anorexia as a problem. Moreover, the head is not completed in the drawing perhaps signifying a cutting off from an awareness of deeper cognitions and emotions. As for challenging thoughts, Betty's false self was much more present that day and although she did say that distracting herself would be one way to decrease the anxiety, it was difficult for her to think of ways to help decrease the anxiety. However, this exercise is notably useful in further understanding the process of how the fear, anxiety and guilt is manifested in the anorexic client as well as discovering the thought processes behind those emotions.

### **Dramatic Scene work:**

As in Hudgins' (1989) latter stage of the therapeutic process, there is a shift in the work in terms of the false self/front stage and true self/backstage. In this later part of the process, the use of psychodramatic techniques, some of which are also known as drama therapy techniques, have been particularly powerful in bringing the true self to the front stage. These techniques include the empty chair, role reversal, doubling and surplus reality which are all combined and incorporated into the drama therapy work.

The empty chair is especially valuable to use in individual therapy because the empty chair can represent the person that the client would like to speak to. Usually, to augment the authenticity of speaking to a real person, I ask the client to choose a piece of fabric, figurine or puppet that the client associates with that person in her life. Moreover:

“Instead of another person (an auxiliary) playing the complementary figure in a protagonist’s enactment, an empty chair represents that position. Sometimes this allows for a more spontaneous expression of aggressive or tender feelings” (Blatner, 1988, p. 164). Sometimes, in doing a scene or re-enactment, multiple empty chairs are used which brings in the next technique, role reversal.

According to Blatner (1988): “When a protagonist in a psychodrama role reverses, it is a way of transcending the habitual limitations of egocentricity. Role reversal is indicated when it is appropriate for the protagonist to emphasize with the other person’s viewpoint” (pp. 174-175). I also find the use of role reversal excellent for the client to portray who else is in the scene thus showing how the client may perceive others in her life. In terms of incorporating cognitive techniques, I use role reversal and doubling to challenge core beliefs and thoughts.

The doubling technique involves the a person, in this case, the therapist to take on the non-verbal posture of the client and verbalizes her inner thoughts and feelings as well as provoking other potential thoughts (Blatner, 1988). As the double, I can say what the client may be thinking and is not saying, and she can agree or disagree with me. The doubling technique is particularly useful in staying true to the client’s experience because as Moreno and Moreno (1969) state: “Interpretation may be questioned, rejected, or totally ineffective, but the act speaks for itself” (as cited in Hudgins, 1989, p. 237). Hence, this returns to the hermeneutic phenomenology perspective which stays committed to the authenticity of the client’s experience.

Another tool that elicits the true self is the use of surplus reality.

Surplus reality provides a fantasy like world, a world with endless possibilities where:

One can enact not only scenes that involve the real events in one's life but also the scenes that have never happened... These scenes often represent hopes, fears, and unfinished psychological business that are experienced as being in some ways more real than the events of everyday existence. (Blatner, 1988, p. 178)

Surplus reality can present a positive and supportive true self thereby helping the client reconnect with her inner strengths. In asking the client to switch into a surplus reality, it gives her the opportunity to play the positive side of her. For the client with anorexia, the flip side of reality is where she is happy with whom she is and she no longer desires to keep the anorexia. The contact that happens with this positive side in the surplus reality does have some effect in engaging the client physically and emotionally in being a supportive true self. Thus, like a seed planted in the soil, the surplus reality plants a seed in the anorexic's mind reminding her to accept her true self and accept working towards a way of health.

A vignette that demonstrates the power of these techniques in making the true self more explicit and present to the client occurs at a later stage in the process with the client Betty. Prior to this session that I will describe, Betty and I had done quite a bit of work with scenes from her life using doubling, surplus reality, role reversal and empty chair. In this particular session, the true self came out the strongest here than in prior sessions. The session began with a discussion on whether it would be helpful for Betty to return to the past through a re-enactment to help the past Betty as a way of resolving the pain that the old Betty experienced and bringing these new coping skills to the present Betty as she is now. Betty agreed that she wanted to try the scene and so she set up the scene with her chair sitting across from the finger puppet which she chose to represent her old self.

Prior to entering the process, Betty explained that at this point in the scene, the old Betty was crying and upset and scared of gaining weight if she had to eat the cabbage. The following is a sample of what Betty, as the guide, said to the old Betty who was crying: “It’s alright, it’s going to be okay, just breathe and stay calm. Think of something else. Close your eyes and when you open them again, it’s going to be okay” (personal communication, February 11, 2002) I felt at this point that although Betty was consoling herself, she was using food again as a disguise of the deeper meanings in her life. Therefore, to bring the work to another level, I un-packaged with Betty the feelings behind the crying. Betty said there was fear of gaining weight, and that to gain weight meant being unhappy even though she is not happy being thin either, a comment she had made herself in a previous session.

The next step was to bring in doubling and I stood behind Betty and said as her double, “You really need to start liking yourself Betty” (personal communication, February 11, 2002). Betty did not agree or disagree immediately and was silent for moment before saying “But she doesn’t like herself”. I asked her then what she was going to do about the situation and she said she did not know, so I added: “You’re stuck, you’re really stuck” and she nodded. At this point, I had come upon the difficulty, the strength of the false self remaining on the front stage even with the acknowledgement of the true self in terms of the unhappiness that Betty was feeling.

As Baker & Hornyak (1989) states: “Intense feelings, often previously less conscious, can surface, and this material can be very useful to the therapy process; however, the therapist must responsibly assess the client’s readiness to experience and tolerate affects that may be aroused” (p. 3). At this period of the therapeutic process, I

felt that the alliance between Betty and I was strong enough to tolerate the next step I was about to take, getting the true self to free itself from the backstage.

I explained that I was going to play the old Betty. So I sat in her seat and said that I, as Betty, was stuck and that I really enjoyed being stuck in my (her) life (personal communication, February 11, 2002). I went on to say that I was leading a very comfortable life being stuck here, and that I did not want to change. After some time, Betty looked at me and spoke up: “You don’t want to stay stuck, you’re unhappy”. I kept up the false self however, and replied, “Oh no, I’m extremely happy here, being stuck, it’s the best thing in the world.” Betty persisted as well, her voice gaining a little more strength each time she responded: “No you don’t want to stay stuck with these feelings, you’re so sad, you don’t want to feel this way forever.” I challenged Betty then by daring her to get me unstuck from the chair even though I said that I bet she could not.

Betty looked at me tentatively, uncertain if she really should, but then she stood up and started pulling my arms first to try to pull me out of the chair, but I refused while repeating loudly, “I want to be stuck, I’m happy here” (personal communication, February 11, 2002). She then began to pull my legs and said, “You don’t want to stay stuck, you don’t”. After a long struggle, she had managed to get me off the chair, but I did not give in easily just as a false self would not disappear that easily. Although she had managed to get me off the chair and onto the ground, I still held onto the chair leg with my hands wrapped tightly around the chair, asserting, “I’m still stuck, I’m going to stay stuck”. Betty did not falter however, she became more persistent in fact and pried each of my fingers off the leg of the chair.

In processing the experience, Betty said she felt satisfied and after remaining in that feeling of success for a little while, I asked her again to talk to her old self and to say what she really wanted to say including what she may be afraid to say before. The reason as to why I asked Betty to do this was because she had undergone a process of self-reconstitution which is described by Sarbin (1976) as: “The process by which an individual is brought to a new understanding of the self...” (as cited in Blumberg & Hare, 1988, p. 92). This time, Betty put the little puppet representing her old self on the chair and sat with the finger puppet on eye level as well as sitting closer to the puppet than previously. Here is an excerpt of what she said:

You can't keep doing this to yourself. You need to stop doing this.  
I know you're stubborn and you want to take care of yourself, but  
you can't go on like this and you can't go onto your trip like this.  
I know you want to hold onto the anorexia, but you need to start listening  
to this other side, you need to start trusting this other side. You can't go  
on like this just eating fat free foods, it's not good for you...Don't be stupid.  
(personal communication, February 11, 2002)

The other side being the guide, the supportive true self that would help her through this time of difficulty. In order to heighten the impact of the true self and to lead Betty to connecting to her own inner therapist, I asked her to pick herself up, herself being symbolically represented by the finger puppet, and to tell her what she has accomplished so far in her life. Betty picked herself up, cradling the puppet in her hand and said that she was proud of her for recognizing that she has a problem, that even though she is taking baby steps, that these baby steps mean something and that she should be proud of the steps she is taking. Betty then said to herself, symbolized by the puppet, that she needs to realize that she is worth something and that there are people around her who really care for her.

The warmth and compassion that Betty expressed towards her old self represented a step in what Bruch (1982) mentions as a rebuilding of the personality after hiding behind a fake existence for a long time (as cited in Treasure, 1997). Hence, there was a progression in the work from the beginning of the therapeutic process to this later stage where and when a most significant step was made in breaking down the false self, and bringing the true self onto the front stage.

#### **Chapter IV: Conclusions and Implications:**

There is an extensive range and variability in terms of what causes anorexia, but as Strober (1991) best puts it: “The ultimate test of any theory’s utility is the extent to which it broadens our comprehension of human functioning....anorexia nervosa is so complex and puzzling an illness that no single theoretical approach can be complete in itself” (p. 371). Thus, having established that, the results of this study do add to the understanding of the treatment of anorexia on two levels. One being the illustration of drama therapy as an effective treatment modality for clients with anorexia and the other recognizing and adding to the literature regarding the anorexic’s true self and false self through the integrated use of Goffman’s dramaturgical model (as cited in Moghaddam, 1998).

As for the findings in regards to the initial hypothesis stated at the beginning of the study, there is material that strongly supports the hypothesis in the work accomplished. The original hypothesis being that an anorectic’s true self/backstage can be brought out through the use of drama therapy and as a result of an acknowledgement of the true self, the cognitive and perceptual distortions that are associated with anorexia may be then worked upon more effectively. To reiterate then the definitions of the true self and false self in this study, the true self is the acceptance and recognition of having a problem, the expression of emotions and other possible underlying issues as well as an acceptance of working towards a healthy way of living. The meaning of the false self includes denial of having a problem either through being completely compliant to the process and not accepting anorexia as a problem and/or by presenting a voice that the

client has “regurgitated” from someone else in her immediate surroundings such as a parent or a doctor to also avoid acknowledging the anorexia as a problem.

The results do indicate the practical use of drama therapy in drawing out the true self and as Bruch (1977) states, regarding the therapeutic process, “Therapy must be directed toward evoking awareness of impulses, feelings, and needs that originate within themselves” (p. 9). The work that was completed in the scene work in addition to the other drama therapy work done directly contacts the client’s awareness through what Landy (1996) explains as a re-experiencing of emotions from the past and future which results in a cathartic release of emotions. Moreover, the use of externalization techniques were very effective as well in creating awareness of the inner state through concretization which as described by Blatner (1992):

To concretize means to change an abstract statement into something more concrete, able to be perceived by visualizing a specific situation or physically experiencing the feelings associated with that situation... The goal is to help patients experience their subconscious dynamics more vividly. (p. 406)

I would also add that the goal is to have the clients reflect on their difficulties from a new perspective and discover new ways of coping with them. Therefore, drama therapy is very effective in bringing out the true self while crediting influences from psychodrama, narrative therapy, CBT and Goffman’s dramaturgical model (as cited in Moghaddam, 1998).

Additionally, the hypothesis is substantiated in that in accepting the true self whereby clients accept and recognize having a problem, they will then want to work towards a healthier way of living by working against the anorexia. This part of the hypothesis is supported by a description from the client Betty who replied that if she

wrote a book on anorexia, she would express the following statement under possible cures for anorexia:

There isn't a cure unless you want to be cured and unless you want to do something. The cure depends on the person because not everyone gets it for the same reason, but if you believe that you will stay like that, then you will stay like that whereas if you believe there is a cure, then you'll take the step to change. (personal communication, March 21, 2002)

Hence, in this testament, there is some awareness that a false self does exist in terms of believing that a cure does not exist unless the anorexic wants to do something about the problem and sees the anorexia as a problem and also indicating that the false self can prohibit any advancement to a healthier path by ways of living, thinking and feeling. However, results from the work also indicate that even though once the true self is accepted in wanting to work against the anorexia, the false self is still very present and as a result, the true self and false self co-exist together with one usually more visible on the front stage than the other in terms of self-representation.

The results illustrate that though there may be a step made in acknowledging having a problem, it was a constant struggle between the true self and the false self with a firm grasp on the false self. This firm grasp may also be otherwise accredited to the client's determination for self-control and which is a common feature in anorexia (Treasure, 1997). I did not refer to the issue of self-control in individual therapy since from my cases, the issues with self-control often related to family difficulties and thus, they were dealt with via family therapy. However, I did acknowledge and sympathize with the client's gradual loss of self-control through the therapeutic process as it is a large step for anorexics to conquer as Steiner-Adair (1991) observes: "At worst, they fear that to connect is to lose oneself in a malevolent, overwhelming presence-and to admit a need

for connection is to put themselves at jeopardy in an annihilating, dependent position...” (p. 231). Therefore, to allow the true self emerge and be on the front stage is extremely threatening in that it also requires the client to relinquish the control factor which is another significant component to anorexia. Regardless of the self-control aspect however, the strong presence of the false self indicate that it would take more than simply an acknowledgement of the true self to abandon the false self completely.

Following the understanding that the client with anorexia may waver between the true self and false self, another part of the original hypothesis that needs to be re-evaluated is the statement that once the true self was accepted, then the cognitive and perceptual distortions that are associated with anorexia can be worked upon more effectively because the true self is accepted. However, as a result of how the therapeutic process actually took place, I began an integrated approach with Cognitive Behavioral Therapy, working on the cognitive and perceptual distortions with the purpose of encouraging the existence of the true self. Examples of the integrated approach include: negative messages, the voice, the body expert as well as in the scene work where in each exercise there is the possibility of confronting the core beliefs. A more precise example is in the voice technique where I, as the interviewer, can question the value of the anorexic’s voice in helping the client in her life and really challenge the thoughts that the voice is perpetuating.

As stated by Stern (1991): “As therapists of eating-disordered patients, we are interested in the conditions necessary to facilitate the re-emergence and integration of the true self: the primary needs and developmental impulses that have been repressed, dissociated, or blunted” (p. 95). The combination of using cognitive behavioral therapy

techniques with drama therapy created a stronger and more effective method in the deconstruction of the clients' core beliefs and providing relaxation techniques as ways of easing the anxiety and fear. As a result of the integration, there occurs the process of what Frankel (1998) explains, "When we allow in what has been disowned and give our attention to it, psychic structures loosen and shift" (p. 4). An example of this is illustrated in the scene work accomplished with Betty where as her double, I was challenging her thoughts, as well as challenging her to get herself (played by me) unstuck from the unhappiness, from the state of anorexia. The result being that as soon as she unstuck her old self from her chair, she could then console her old self (played by a puppet) and show care and insight in wanting to change the anorexia. Thus, the interaction amongst the cognitive aspects and the behavioral aspects reinforces and feeds the place of the true self on the front stage.

In regards to how the methodological framework contributed to the work of this study, hermeneutic phenomenology was extremely useful in bringing meaning to the work by the combined efforts from the client and I as the therapist and with an emphasis on the client's experience of the world. As Betty's double, I was able to help voice the feelings that Betty had not yet been aware of or could not verbalize as of yet. However, I also gave the choice to Betty as to whether or not my verbal statements were correct with how she was really feeling so as to stay true to her experience. In having a strong therapeutic alliance with my clients, I trusted that my clients could and would tell me if they were feeling uncomfortable. I would also routinely check in with them throughout the process to see if they are alright with what is taking place in the session. In addition, Strober (1991) mentions the significance of staying close to the client's experience while

investigating into her inner world to discover the fear, the lack of assertiveness, the anxiety, the helplessness and worthlessness that are commonly associated with anorexia. Therefore, instead of holding back interpretations and assumptions, I used them as investigative tools to go deeper into the clients' world, while still confirming with the client as to whether the interpretations are true to their own experience.

In conclusion, the findings from this study do implicate that future work should be done on the use of drama therapy and treating anorexia as the results here support a promising treatment with clients with anorexia. As illustrated from this study, the true self is extremely fragile and drama therapy can strengthen the true self in helping the client build a healthy identity. Moreover, as Blatner (1992) states: "Helping patients develop their creativity-another principle that is particularly powerful in itself-involves not only fostering their creative ability, but also building their sense of themselves as creators..." (p. 407). Thus, drama therapy is not only providing a treatment to eliminate the anorexia, but it is also offering a rebuilding of a newer and stronger self in replacement.

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**Appendix A  
Consent Form**

**Drama Therapy Research Paper  
Synthia Tom  
Masters in the Creative Arts Therapies Programme  
Concordia University**

I, \_\_\_\_\_, give permission to \_\_\_\_\_ to photograph and audiotape my child's creative work for inclusion in his/her master's research paper in the Creative Arts Therapies Programme at Concordia University.

I also give \_\_\_\_\_ permission to have access to my child's medical and social service files for the purpose of writing her research paper.

I understand that both my child's name and the setting where her/his drama therapy sessions took place will be kept strictly anonymous and that no identifying information will be given in the research paper. I also understand that I may withdraw my consent any time before the research paper is completed, without explanation, simply by contacting Synthia Tom or her Supervisor, \_\_\_\_\_. This decision will have no effect whatsoever on my child's drama therapy or any other aspect of her/his medical treatment.

I have read and understood the contents of this form and I give consent as described above to \_\_\_\_\_ to utilize and publish case material for educational purposes, provided precautions be taken to conserve confidentiality.

I have had an opportunity to ask questions about the implications of this consent and I am satisfied with the answers I received.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Appendix B  
Consent Form**

Autorisation pour photographie, enregistrements sonores et l'utilisation du matériel clinique de ma fille/fils au sujet du Drama Therapie.

Je, soussigné(é) \_\_\_\_\_

Autorise \_\_\_\_\_

À prendre/utiliser:

	Oui	Non
Photographies	_____	_____
Enregistrements sonores	_____	_____
Matériel clinique	_____	_____

Je donne également la permission à \_\_\_\_\_ d'avoir accès à son dossier médical et social afin de pouvoir rédiger son projet de recherche.

Je comprends que son nom ainsi que l'endroit où ses thérapies ont eu lieu seront gardés confidentiels et aucunement mentionnés dans la rédaction du projet. Je comprends également qu'il est possible de retirer mon consentement, en contactant Synthia Tom ou sa directrice de stage \_\_\_\_\_ en tout temps avant la rédaction du projet et ceci sans devoir fournir d'explications. Une telle décision n'affectera en aucune façon sa thérapie ou ses soins médicaux.

J'ai lu et j'approuve les conditions de ce consentement et j'autorise par la présente \_\_\_\_\_ à utiliser et à publier des informations concernant ma fille/mon fils à des fins éducatives à condition que des précautions raisonnables soient prises pour que la soit conservé confidentialité.

L'opportunité de poser des questions par rapport aux implications de ce consentement m'a été proposer et je suis entièrement satisfait(e) des réponses qui m'ont été offertes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Témoin

\_\_\_\_\_  
Date