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Drama Therapy and CBT: An Integrative Approach in Treating Anorexia Nervosa

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A Research Paper

in

The Department

of

Creative Arts Therapies

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ABSTRACT

Drama Therapy and CBT: An Integrative Approach in Treating Anorexia Nervosa

Saman Fereydoonzad

This research paper is comprised of an extensive literature review outlining the nature of Anorexia Nervosa, followed by an exploration of the current treatments used to address the disorder. The literature suggests that among the forms of intervention used for Anorexia Nervosa, which include Family Therapy, Arts Therapies, and Cognitive Behavioural Therapy, the latter seems to be a consistent choice for the treatment of this eating disorder. Furthermore, relatively new research by Fairburn, Cooper and Shafran, (2002) indicates that there are four mechanisms that contribute to the continuation of Eating Disorders: clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties. They further argue that since Anorexia Nervosa, Bulimia Nervosa, and EDNOS share common psychopathologies that this theory is transdiagnostic and applies to all of them. It is argued that although beneficial, Cognitive Behavioural Therapy has the tendency to over intellectualize problems (Matto, 1997), which is why this paper proposes an integrated approach that involves addressing the four maintaining mechanisms through Drama Therapeutic techniques. The intention of this program design, which takes place over the course of 20 sessions, is to combine a cognitive approach, with one that uses drama to access deeper emotional content, in hopes of providing the patient with a well rounded therapeutic intervention that will help in her outpatient recovery process.

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Subject Area of Study

This research paper intends to explore research, therapeutic techniques, and programs currently used in the treatment of *Anorexia Nervosa* (Anorexia), with the goal of creating a Drama Therapy program that can be implemented in outpatient programs, treating adolescent girls. Eating disorders have become exceedingly present in today's society, with approximately 0.5 to 3.7 percent of the world's female population, suffering from the disease at some point throughout their lifetime (National Institute of Mental Health, 2001). This high incident rate has been attributed to ideals in the media and in fashion models (Ahern, Bennett, & Hetherington, 2008), in addition to a combination of psychological, physical, emotional and cultural pressures (American Dietetic Association, 2001). Various therapeutic interventions have been applied to the treatment of Anorexia with a number of different approaches. The most common approach found in the literature has been Cognitive Behavioural Therapy (CBT). Goleman (1995) writes that the purpose of CBT is to improve patients' methods of interpreting their thought process, developing more appropriate strategies to help cope with issues, as well as to alter distorted perceptions towards the body, by facing unfounded beliefs and changing them. Matto (1997) notes that one limitation of CBT is that, if it is used as the sole method of treatment, it can potentially draw focus to the intellectual components of the disorder, therefore neglecting to explore the emotions that are involved. Matto therefore proposed an integrative CBT- Art Therapy approach. The art would allow for patients to express their emotions creatively, helping to balance the cognitive work, and therefore making the therapeutic experience more balanced. In Drama Therapy, both Wurr and Pope-Carter (1998) as well as Hinz and Ragsdell (1990) unsuccessfully used a similar

approach in the treatment of eating disorders. However, Hamamci (2006) combined dramatic role-playing with CBT and argued that this combination could alter negative moods, thoughts and dysfunctional behaviours. It is therefore my intention to survey both successful and non-successful therapeutic techniques used in the treatment of eating disorders, as well as current Drama Therapy approaches, to develop a therapeutic program to help focus on cognitive, behavioural, emotional, and psychological aspects of Anorexia Nervosa.

Anorexia Nervosa

The American Psychiatric Association (APA, 2000) has reported that eating disorders are now the third most common form of chronic illness, and thus it is important to find new and innovative treatment programs for this pervasive disorder. In fact, the mortality rate for Anorexia Nervosa is as high as the ones found in any psychiatric disorder. Anorexia Nervosa and Bulimia Nervosa are two types of eating disorders whose prevalence is noticeably rising in today's society and they affect 10 times the number of women than men (Goleman, 1995). Until recently these disorders have been considered to affect mostly Western, Caucasian females, however, eating disorders in other racial and ethnic groups are significantly increasing (Bulik, 2002). The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR, 2000)*, defines Anorexia Nervosa as an unrealistic fear of weight gain, self-starvation, and distortions of body image. There are two subtypes of Anorexia Nervosa -- a restricting type, characterized by strict dieting and exercise without binge eating; and a binge-eating/purging type, marked by episodes of compulsive eating with or without self-induced vomiting and the use of laxatives or enemas.

Prevalence of Anorexia

The age group, for whom the aforementioned intervention program is intended, is for adolescent girls between the ages of 13 and 17. The reason the program is targeted towards adolescents is due to the high prevalence rates of eating disorders that begin at that age. In 2001, the American Dietetic Association reported that more than five million Americans were diagnosed with an eating disorder, and 85% of them began during adolescence. As indicated by Fairburn, Cooper, and Shafran (2003), eating disorders that are developed during early-to mid-adolescence, most often take the form of Anorexia Nervosa. It is not until late adolescence and early adulthood that the disorder morphs into Bulimia Nervosa or an eating disorder not otherwise specified, meaning an eating disorder that does not fit perfectly into the criteria required for Anorexia or Bulimia, but that borrows aspects from both. It is therefore important to intervene and address the disorder while it is in its beginning stages. Although somewhat scarce, males too are affected by eating disorders and comprise of 19 to 30% of younger patients with Anorexia Nervosa (American Dietetic Association (ADA), 2001). In addition to the high prevalence rate of this disorder, Steinhausen (2002) notes that the recovery rates are relatively low, given that more than half the patients do not recover, and consequently are at risk for developing a chronic illness. There is an abundance of physical side effects caused by Anorexia, some of which are listed by medical doctors Attia and Walsh (2007): osteoporosis, poor concentration, increased irritability, hair loss, and feeling cold. Additional side effects were listed by Robin, Gilroy and Dennis (1998), who did specific research on child and adolescent eating disorders, and found that these patients are also at

risk for: stunted growth, sterility, incomplete development of secondary sex characteristics, and abnormal structure of the brain.

Onset and Psychopathology of Anorexia Nervosa

The American Dietetic Association (2001) explains that the onset of anorexic symptoms are due to a combination of physical, psychological, emotional, and cultural pressures. A study conducted by Nilsson, Abrahamsson, Torbiornsson, and Haggof (2007), contributed to the ADA's causes of Anorexia, by adding the familial element, as well as elaborating upon the socio-cultural stressors. Nilsson et al.'s study looked at the perspectives of adolescents with Anorexia, in regards to what they believe the causes of onset to be. In spite of the socio-cultural and familial causes, the findings showed that the most common cause of Anorexia is attributed to the individual's high self demands, and or perfectionist nature. In a study to investigate assumptions and beliefs in Anorexia and dieting (Cooper & Turner, 2000), anorexic patients, dieters, and a control group were compared and given a questionnaire. The results showed that the cognitive content of Anorexia patients had a higher score on negative self-beliefs and assumptions about eating, differing a great deal from those of the dieters. Fairburn et al. (2003) elaborate on the concept of the 'self' being the greatest cause of Anorexia, by explaining that these patients are extremely self critical; their high and unrealistic goals cause for them to feel like failures if the said expectations are not achieved. Individuals suffering from this disorder are found to have low levels of self-esteem, feelings of being helpless, as well as dissatisfaction with their appearance (ADA, 2001). The literature suggests that clinicians and researchers have found that anorexics overestimate their body size, and the higher the patient's level of psychopathology, her body image distortion will consequently be higher

as well (Kaslow & Eicher, 1988). Although many anorectic patients are unable to see that they have a problem (Attia & Walsh, 2007), there are psychological developments that occur as a result of the starvation (Schiele & Brozek, 1948), which are depression, anxiety, obsession over food, and rigidity about eating.

As previously discussed, the adolescent patients in the study conducted by Nilsson et al. (2007) said that they found family to be one of the main causes of the onset of their Anorexia. Levens (1995) explores this phenomenon by explaining that often times eating disorder patients feel that they have a little sense of self, and as though they have no voice within the family unit. As a result, they may feel a lack of self-direction, and as though they are unable to have an effect on those around them, due to their 'invisibility.' In turn, these individuals will take measures to regain a sense of power by controlling the only thing belonging solely to them: their bodies.

Levens (1995), being an art therapist, uses a very powerful picture, drawn by a patient suffering from an eating disorder, to depict the self-perception of these individuals. The picture is of a person whose head is detached from her body, as are all her parts. This is an appropriate representation of the mind and body splitting, which is part of these patients' struggle. This splitting perception may help them to disassociate from their bodies, leaving their true selves and their bodies as two separate entities. The benefit of this disassociation being that they now view their bodies as separate objects that they can punish, or do with as they please. These cruel actions will allow the patients to feel powerful, seeing as how they have gained full control of an object; their bodies.

Current Treatments

Progressive therapeutic programs for the treatment of Anorexia are pertinent because there is often reluctance for patients to seek treatment, but Attia and Walsh discovered (2007) that they would do so at the request of family or health care providers. Therefore, it is important that once in therapy, the clients receive powerful interventions that ignite their desire to help themselves.

The treatment of eating disorders has proven to be exceedingly difficult in today's ultra thin society, where there is pressure for young women to conform to often-unrealistic ideals (Ahrem, Bennett, & Hetherington, 2008). Currently, effective therapeutic approaches have been found to focus on physiological treatments forcing weight gain, behavioural changes, and psychological side effects such as mood and anxiety (Attia and Walsh, 2007).

Family Therapy

Attia and Walsh (2007) suggest that the most effective approach for children and adolescents with the disorder is family-based. This argument is further perpetuated by Eisler, Simic, Russel and Dare (2007), who in a 5-year longitudinal study with adolescents with Anorexia Nervosa, determined that family-based approaches were effective when the family was treated individually or together. After five years of having completed either outpatient 'separated family therapy,' or 'conjoint family therapy,' the results showed that 75% of the participants had no symptoms of an eating disorder. The only apparent difference between the two forms of family therapy, was that patients who were receiving high levels of maternal criticism and who were concurrently in conjoint family therapy. These patients did less well than those with equal levels of maternal

criticism, who were getting separated family therapy, and the results persisted at follow-up, for the patients had not gained any weight since the end of their outpatient treatment. These results suggest avoiding the use of conjoint family therapy early on in the treatment of Anorexia Nervosa, if there is a high level of maternal criticism within the family.

Eisler, Simic, Russel, and Dare's (2007) study lends itself to the integrated treatment that will later be proposed. Cognitive Behavioural Therapy, which will be discussed in further detail in a following section, promotes the idea of helping clients become aware of their maladaptive thoughts, emotions, and behaviours (Rachman, 1997). Matto (1997) uses self monitoring treatment where patients were asked to record technical information such as caloric intake, purging, exercise, and food, as well as to take note of emotional states experienced that cause particular feelings. When treating Bulimia Nervosa for instance, it is important to determine what instances trigger the loss of control leading to the patient's eating disorder, in order to regulate their eating habits. CBT would therefore help patients to address and regulate both their emotional and physical problems. Considering that family was named by former Anorexia Nervosa patients, as being one of the main causes for the onset of their disorder (Nilsson et al., 2007), once this problem was identified through the use of identifying triggers, the patients could address their feelings towards family members through role play (Landy, 2008) a popular technique in Drama Therapy. The role playing that would be used to address family members would allow for the client to feel some of the benefits of separated family therapy, without the confounding variable of adding the family to the treatment. They would be given the opportunity to embody their parents and siblings, in

order to gain perspective on their own thoughts and feelings, as well as those of their family members.

Looking back in history, a family's dysfunction was considered to be the cause of Anorexia Nervosa. The rigid organization within the family unit was considered to bring forth the Anorexia, which was acting as a homeostasis function (Dare, 1983). The Maudsley Method, which was developed at the Maudsley Hospital in London, England by Dare and his colleagues (Dare, 1985; Lock, le Grange, Atras & Dare, 2001), is an integrative approach based upon various forms of family therapy, which is best suited for adolescent patients who have had Anorexia for less than three years (Rhodes, 2003). Russell, Szmukler, Dare and Eisler (1987) conducted a clinical trial with 80 patients suffering from Anorexia, in order to determine whether individual or family therapy was the most effective form of intervention. The results showed that patients under the age of 18, and whose disorders were under a three year duration, would benefit from family therapy. For patients over the age of 18 whose disorders had persisted for over three years, individual therapy was deemed as being the more effective of the two. The Maudsley method is a form of family therapy that helps empower the parents of the patient with the eating disorder, to refeed their child. The family's negotiation around eating can allow the patient to return to a normal adolescent development (Attia & Walsh, 2007). In this method, the parents are directly responsible for the child's eating behaviours, the siblings play the role of supporters, and there is no placing of blame for the development of the eating disorder (Marx & Herrin, 2005). The patient regains control over her eating once she is back to a healthy weight. This method encourages parents to find their own ways of controlling their child's eating behaviours, but also

offers them help through the treatment. Families are asked to bring a meal to one of the treatment sessions so that they can participate in “coached” family meals. During this ‘meal,’ the family would go about eating and conversing as per usual while the professional assesses them in terms of their patterns of interaction, so that she can help coach the parents in how to convince the child to eat more than she wishes to (Marx & Herrin, 2005).

Morris (2008) writes that when dealing with Anorexia, patients often become involved in Cognitive Behavioural Therapy, which deals with the disorder in more of a technical way, but it is important for the family to be involved in the process to help with the ‘bigger picture,’ and to hold things together. Morris considers the Maudsley method to be successful in this domain, because of its behavioural family work. In spite of its use of the whole family, the Maudsley method is based around food and seems to be more of a behavioural approach. The integrative approach that will be proposed in the final section of this paper will argue that Drama Therapy can implement the idea of incorporating the presence of the family within the therapy, through the use of projective techniques. These techniques will in turn help the patient gain perspective on the familial relationships that may be causing her inner turmoil.

Theatre Intervention

Before entering the Cognitive-behavioural approach, it is important to explore the following theatre-based intervention. Theatre has the effect of being very therapeutic and this concept will be further explored in the section on Drama Therapy. Although this particular intervention was led by professional actors and not by Drama Therapists, its effects are still apparent and worth noting. In 2008 Haines, Neumark-Sztainer, and

Morris conducted qualitative research to determine the effectiveness of a school-based intervention, where the aim was to use theatre as a strategy to change behaviour. Weight related issues are prominent among children (Ogden, Carroll, Curtin, McDowell, Tabak & Flegal, 2006), which is why the study sample consisted of 18 students between grades four and six. The participants were involved in this process for ten sessions, meeting once weekly. The early stages of the process involved the development and writing of the script, in addition to the theatre staff facilitating activities that allowed the children to explore and share their feelings about their bodies. An example of these activities is narrative work such as stories or poems. The children would use the narrative technique to write about their bodies, and these pieces would later be developed into a scene for the final product: the play. A similar theatre-based intervention had been attempted by Irving (2000) who had a play developed by Eating Disorder Awareness and Prevention Inc., with the intent to teach children about body shape/size awareness and the effects of teasing. This play was performed by trained puppeteers, and succeeded in getting its messages across to a small sample of the elementary school students. A similar program was implemented for middle-school students, to promote healthy eating/weight, body size acceptance, and general self-acceptance. This performance too was developed as well as performed by a drama department who was hired by those running the study. There was a reduction of the internalization of the thin ideal, and dieting behaviours amongst the girls who witnessed the performance, but no particular changes were noted for the boys (McVey & Tweed, 2005, as cited in Haines, Neumark-Sztainer & Morris, 2008). The difference between Irving, McVey and Tweed's interventions, in comparison to the study in question, named V.I.K. (Very Important Kids), is that the latter allowed the children to

develop and perform the play. This approach gave the children the opportunity to bring in their personal life experiences, which made the final product more relevant to them and to their target audience of peers. In addition to the material's relevance, the creation and performance of the play helped increase the students' resilience to weight related comments made by others. Finally, this process taught the children skills to help them better communicate with their peers in terms of dealing with conflict, and enhanced their overall body satisfaction and raised their self confidence. When the participants were asked for their opinions on how to improve the theatre program, one of the responses was to decrease the amount of "goofing off" that took place during their rehearsals. This statement provides a rationale for why it would be beneficial to have individual sessions with a professional Drama Therapist, in the intervention program that will be provided through this research. This point will be touched upon in more detail, along with the implications that this study has for the use of Drama Therapy with Anorexia Nervosa, in the 'rationale for intervention' section. Another influential therapeutic technique used for Anorexia is Cognitive Behavioural Therapy (CBT).

Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) focuses on helping clients become aware of their maladaptive thoughts, emotions, and behaviours, cyclically perpetuating their negative perceptions, in hopes of helping the clients learn to stop the cycle and correct the behaviours (Rachman, 1997). While focusing on *Bulimia Nervosa*, Goleman (1995) proposed that the aim of CBT is to improve patients' methods of interpreting their feelings, developing appropriate strategies for facing unfounded beliefs, and changing them. Matto explores this approach through a self-monitoring treatment where patients

were recording technical information such as caloric intake, purging, exercise, food, etc., in addition to emotional states experienced and physiological triggers that provoke particular feelings. The primary focus when treating Bulimia through the use of CBT is to regulate eating habits; this is done by determining what instances trigger the loss of control leading to the patient's binging/purging, as well as by tuning into the physical signals that trigger specific emotions within the individual.

With specific concern to Anorexia Nervosa, a study was conducted by Cooper and Fairburn (1984) that adapted the use of the CBT with Bulimia Nervosa treatment, for five patients with Anorexia Nervosa. Based on the general acceptance that Anorexia Nervosa is difficult to treat, and that interventions seldom have long-term recovery effects, Cooper and Fairburn attempted to address and alter the patients' distorted eating habits, beliefs, and values, through the use of cognitive behavioural treatment. The reason for their focus on both the physiological, as well as on the psychological, was that previous studies showed them that although anorexic patients showed improvements in their weight after treatment, they continued to show various symptoms of the eating disorder such as self-induced vomiting, avoidance of particular foods, bulimic episodes, and laxative abuse. In the past, the patients also maintained the distorted thoughts characteristic of Anorexia Nervosa after treatment, such as shape and weight distortion. The aforementioned symptoms must be addressed within the course of treatment, in order to achieve a full recovery. Cooper and Fairburn had to make modifications to the CBT treatment when applying it to patients with Anorexia due to their need to gain weight and their lack of motivation.

The CBT treatment consisted of three steps, but in order to begin the process, it was important for the patients to identify what they considered to be problems in the early sessions, in addition to forming a strong therapeutic alliance. The patients' problems were typically in the realms of loss of control in regards to eating, dietary preoccupations, and feelings of being cold. The therapists informed the patients that these problems could be attributed to their starvation, and used that opportunity to inform them that if they were willing to gain a limited and controlled amount of weight, that they could expect to see improvements regarding those issues. In order to move towards the first stage of therapy, patients were presented with the goal of gaining weight. They were assured that they would be supported in learning how to gain control over their eating, while putting on weight as a beginning step in therapy. Once the weight gain was accepted, stage one of the therapy commenced, consisting primarily of psychoeducation about appropriate weight gain based on their age and height, in addition to being given dietary conditions. This first stage was difficult and required patients to be seen frequently for 50-minute sessions, and sometimes even daily. Once a significant amount of weight was gained, the second stage of treatment, which was similar to that of Bulimia, began. This stage consisted of reducing the patients' dietary restraints, psychoeducation about the disorder, and giving them advice on how to cope with their body image misperception. The third and final stage, which once again followed that of the treatment for Bulimia very closely, was comprised of ensuring that the progress made by the patients was maintained. When examining the case studies of the five patients, certain themes and commonalities kept reoccurring. The effects of Anorexia on these girls consisted of: depression, a want for control, stealing, withdrawal from social

activity, lack of desire to change, inflexible routines, self-depreciatory thoughts, impaired concentration, and distress. The results of this study showed that this approach was somewhat successful for the anorexic patients who had bulimic episodes, due to the self-control strategies provided to help them eliminate the bingeing and purging sequences. The patients' cooperation, in terms of gaining weight early on in the process, allowed for further cognitive behavioural change. The patients who restricted their food intake on the other hand did not show significant change in terms of recovery, and continued to maintain their original lack of motivation. Therefore, despite numerous sessions of Cognitive Behavioural Therapy, the success rate was low. The approach proved to be somewhat effective for the bulimic sub-group of anorexics, but not with the restrictive type. Perhaps, if coupled with Drama Therapy, this approach would better meet the clients' physical, psychological, and emotional needs.

Although CBT has its limitations when used as the sole method of treatment, (Matto, 1997) there is a study (Pike, Walsh, Vitousek, Wilson & Bauer, 2003) that shows it to be far superior to the more technical forms, such as nutritional counselling which addresses the patients' eating behaviours, and need for weight gain, much like in CBT. Once they were no longer in-patients, 33 individuals who had been diagnosed, based on DSM-IV criteria, with Anorexia Nervosa, were randomly assigned to either Cognitive Behavioural Therapy or to nutritional counselling, for one year of outpatient treatment. The treatment consisted of 50 individual sessions of each form of intervention; 18 patients were placed in Cognitive Behavioural Therapy and 15 in nutritional counselling. The results indicated that Cognitive Behavioural Therapy was significantly more effective than nutritional counselling in terms of improving patients' outcomes and in

preventing relapses; in addition, Cognitive Behavioural Therapy had a lower attrition rate than did nutritional counselling. Therefore, the conclusion can be drawn that although CBT may run the risk of intellectualizing one's problems rather than dealing with the emotions involved (Matto, 1997), it is a superior form of treatment when compared to others that share the same goals in terms of psycho-education, food plans, and weight gain.

In a study conducted by Vanderlinden, Buis, Pieters, and Probst (2007) 132 eating disorder patients were asked to evaluate what they considered to be the elements in their treatment that helped the most with their recovery. This study stood out amongst the other studies of the same topic because of its consideration of the patients' view point in regards to what they found to be effective in their recovery process. The patient views were then compared to those of 49 therapists who are experts in the area of eating disorders. The findings suggest that there is not much of a discrepancy between therapist and patient views, which according to Clinton (1996) is an essential component of therapy, because differing expectations between patients and therapists is a known cause of increased attrition rates. It is important for therapists and patients to be working towards common goals, and for there to be a strong therapeutic alliance within the dyad, in order for therapy to progress successfully. Button and Warren (2001) support this idea in the realm of working with Anorexia Nervosa. They note both the importance of individual psychotherapy for this population, as well as the value of having the therapist be supportive and empathic within the therapeutic relationship.

All patients in the study (Vanderlinden, Buis, Pieters, & Probst, 2007) received group Cognitive Behavioural Therapy, combined with a family therapeutic approach. The

treatment consisted of two phases. The first phase was comprised primarily of psycho-education, motivation, normalizing of eating, ceasing of purging, and weight restoration. Patients were presented with a contract that indicated strict and clear arrangements that were to be followed throughout the course of that phase. Once the patients had improved eating habits and gained weight, new treatment plans were introduced based on their progress and needs. Essentially, the second stage of treatment was aimed at improving the patients overall self-concept; family members were involved in the treatment. This was attempted by altering misconceptions about their bodies, weight, and physical appearances, by improving their self-esteem, and by learning about the origins of their eating disorder. Furthermore, the patients worked on becoming more autonomous by means of learning problem solving skills and to become more assertive. Finally, the patients were supported in addressing their perfectionism as well as their interpersonal relationships, with emphasis on decreasing the former and increasing the latter.

Patients and therapists (Vanderlinden, Buis, Pieters, & Probst, 2007) were given a questionnaire with 20 of the key elements that were used therapeutically in the treatment, and were asked to use a likert-scale to rate them from one to ten, to help determine which aspects they considered to be essential in the recovery process. The patient views indicated that 'improving self-esteem,' 'improving body experience,' and 'learning problem solving skills' were what they considered to be the most important elements in their treatment. Following the core elements, factors such as 'support of the therapist' and 'learning to express one's opinion and feelings,' were also deemed as being very important. Finally, although 'getting insight in their problems and underlying mechanisms,' was not rated among the core elements, patients still highly appreciated it

during treatment. Therapists shared similar views to those of the patients, and considered the increase of a patient's self-esteem to be the number one priority in the treatment of eating disorders. Secondly, they viewed increasing motivation to work through the eating disorder, learning to evaluate the body positively, and improving the body experience, to be the important ingredients in treatment. Although parental and family support was given the lowest score, it was still considered to be important in the recovery process. The data from this study supported the view of the aforementioned studies and researchers that family therapy should be part of the treatment plan for treating Anorexia Nervosa. Family therapy is often considered an essential component of treatment programs for younger patients with Anorexia Nervosa (Eisler, Dare, Russel, Szumukler, Le Grange & Dodge, 1997). However, when looking at the data from the subsections within the sample, the conclusion can be drawn that family therapy is beneficial for restrictive Anorexia, as well as for older patients with the disorder, and that it should be implemented in their treatment programs.

The elements of therapy that the patients from the aforementioned study found to be essential in their recovery were precise. Although some of them could be worked on in a cognitive manner, the integrative Drama Therapy and CBT program will work towards these core elements in a way that is not solely based on one's mind set. By using Drama Therapy techniques such as dramatic projection (Jones, 1996), role play (Landy, 2008), and embodiment (Jones 1996), the client will be able to alter her self-misconceptions through the body, mind, and soul (Chutroo, 2007), allowing her to repair her self-concept. As noted by Button and Warren (2001), when working with anorexic patients, the quality of the therapeutic relationship is of great importance; the therapist should show support

and empathy. Chutroo also discusses the role of the therapist, but in terms of creative arts therapies. The creative arts therapist allows the client to safely explore the stages in which she feels stuck, and works to repair those experiences, in hopes of helping her to move forward.

Mechanisms of Anorexia Nervosa

A very important theory and treatment have been developed by Fairburn, Cooper, and Shafran (2003). Their research sheds light on two areas that are later woven together for a greater good. The paper starts by looking at the cognitive behavioural theory of Bulimia Nervosa, which is considered to be the leading theory in the maintenance of eating disorders. The authors believe that this theory should be extended to address four other mechanisms that they believe contribute to patients' maintenance of the disorder. The four additional areas that they believe are pertinent to address in the treatment of the disorder are: the influence of clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties. Fairburn, Cooper, and Shafran propose that in certain patients, in addition to the core eating disorder mechanisms, one or more of these four maintaining processes occur and interact with the latter, which then becomes a challenge to reverse. The second argument is that eating disorders, particularly Anorexia Nervosa, Bulimia Nervosa, and atypical ones that are not otherwise specified, despite their distinct clinical features that set them apart from one another, share similar psychopathological processes. It is further proposed that, since the eating disorders are believed to have common psychopathologies, one theory can address a broader range of all of their mechanisms.

Table 1. Eating Disorders

	Clinical Criterion (Morrison, 2001)	Psychopathologies (Fairburn, Cooper & Shafran, 2003)
Anorexia Nervosa	<ul style="list-style-type: none"> • Minimum body weight is not maintained • Extreme fear of weight gain or obesity despite being underweight • Abnormal self-perception of the body seen through at least one of the following: <ol style="list-style-type: none"> 1) Excessive and unnecessary emphasis on weight/shape in self-evaluation. 2) Denial of seriousness of low weight 3) Distorted perceptions of personal body shape or weight. • Amenorrhea – three consecutively missed menstrual periods due to weight loss. • Two types: 1) Binge-Eating/Purging type • 2) Restricting type 	<ul style="list-style-type: none"> • Over-evaluation of eating, shape, weight • In most cases the main focus is to control eating. • Rigid attitudes and behaviours • Incessant body checking • Preoccupation with thoughts regarding shape, weight, and eating. <p>* Often occurs in mid-adolescence.</p>
Bulimia Nervosa	<ul style="list-style-type: none"> • Repeated eating in binges • Binge episode: amount of food consumed is more than most people ordinarily eat in comparable circumstance and in a similar time span. The eating feels 'out of control' for the patient. • Weight gain is continually controlled inappropriately through: 	<ul style="list-style-type: none"> • Over-evaluation of eating, shape, weight • Focus on controlling personal shape and weight. • Rigid attitudes and behaviours • Incessant body checking • Preoccupation with thoughts regarding shape, weight, and eating. <p>* Often occurs in late-adolescence or early-</p>

	<p>fasting, self-induced vomiting, excessive exercise, abuse of laxatives, diuretics, or other drugs.</p> <ul style="list-style-type: none"> • The above behaviours have occurred a minimum of two times a month for three consecutive months. • Self-evaluation is excessively affected by body shape and weight. 	adulthood.
<p>Eating Disorder Not Otherwise Specified</p>	<ul style="list-style-type: none"> • Patients do not meet criteria for Anorexia Nervosa or Bulimia Nervosa but have problems regarding appetite, eating and weight. • Patients may meet many criteria for Anorexia or Bulimia ex: • Anorexia, normal menses: patient shows symptoms of anorexia, low weight, fear of weight gain, distorted self-image, but does not experience amenorrhea. • Anorexia, normal weight: considerable weight loss, fear of weight gain, belief of looking fat, weight remains within normal range. • Bulimia, infrequent binges: all criteria for Bulimia Nervosa is met, but bingeing occurs less than twice a week. • Inappropriate weight control, normal weight: frequent vomiting or alternative 	<ul style="list-style-type: none"> • Over-evaluation of eating, shape and weight. • Need for control • Characteristic psychopathological features can be combinations of ones from Anorexia Nervosa and Bulimia Nervosa.

	<p>inappropriate weight control behaviours are engaged in after consumption of small food portions; weight remains normal.</p> <ul style="list-style-type: none"> • Binge-eating disorder: food is consumed binges but inappropriate weight control behaviours do not follow. 	
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A review of the Fairburn, Cooper, and Shafron (2003) article is pertinent, for it will comprise the structure of the proposed Drama Therapy intervention to follow. The article begins with an overview of cognitive behavioural treatment for Bulimia Nervosa, which has already been outlined in the previous sections of this paper. The article continues by providing evidence that supports the use of cognitive behavioural theory for the disorder, explaining that its efficacy has been established in over 50 randomized control trials and 20 studies, and is found to be more effective when compared to a number of psychological interventions. Within the 80-85% of patients who complete treatment, 40-50% of them succeed in recovering fully, eliminating all bingeing and purging behaviours, and maintaining their recovery in the long-term. In spite of the success rate, the fact remains that CBT for Bulimia is not effective enough seeing as how only half the patients have shown that they have had a full and continuous recovery. Before proceeding with the article's proposed theory, it is important to note that there is a great emphasis placed on the similarities between Bulimia and Anorexia (See Table 1), leading to parallel psychopathologies, allowing for a treatment that is relevant to both branches of eating disorders, as well as to the atypical ones. Seeing as how many authors, including the innovators of this theory, believe that the current treatment for

Bulimia is too narrowly focused (Hollon & Beck, 1993; Meyer, Waller & Waters, 1998, as cited in Fairburn, Cooper & Shafron, 2003), concentrating mainly on the clinical features associated with the disorder, a broader approach is encouraged.

The following section is comprised of a description of the four additional mechanisms (See Table 2) suggested as the core components of eating disorder patients; it is recommended that they be addressed as part of the cognitive behavioural treatment for eating disorders. The four mechanisms (clinical perfectionism, core low self-esteem, mood intolerance, and interpersonal difficulties) will be used as the basic structure for the Drama Therapy treatment program. Drama Therapy techniques will further be applied to address each of the four mechanisms within the client, in hopes of combining the efficacy of CBT with the less cognitive, more emotion-based approach of Drama Therapy. The first mechanism, “clinical perfectionism,” was re-evaluated by the authors in order to provide a cognitive behavioural definition of it, considering it is a widely used term. They define clinical perfectionism as being destructive to an extreme that requires clinical attention. The core characteristic of this form of perfectionism is over striving to accomplish personal standards, which in these cases are demanding and un-realistic, even if it results in negative consequences. It is suggested that the psychopathology of clinical perfectionism consists of a self-evaluation process which determines self-worth through the successful completion of demanding personal goals. Patients will often combine the innate psychopathologies of the eating disorder with clinical perfectionism, causing them to apply the perfectionist standards to their eating, their weight, and their performances in their respective lives (work, school, sports), in attempts of gaining control and achieving their goals. Like in most people, elevated expectation can often be a cause for

disappointment. Similarly, these patients have a fear of failure in regards to maintaining or obtaining their ideal body shapes, in turn translating into self-criticism based on their biased failure of performance, causing negative self-evaluation, resulting in an even higher and more unrealistic drive to achieve goals that aid in the perpetuation of their eating disorder.

The second mechanism, “core low self-esteem,” has similar characteristics to “clinical perfectionism.” This occurs when patients have an unconditional negative view of themselves that they do not have the ability to control and that is not reliant upon their performances, and therefore remains unaltered, despite changes in their eating disorder. Ordinarily, patients with Bulimia carry with them a great deal of self-criticism based on their inability to achieve their goals. This negative self-evaluation usually gets repaired through treatment, but in the case of the aforementioned subgroup of patients who have core low self-esteem, the mechanism needs to be addressed as its own entity rather than to be corrected through general treatment of the eating disorder. Core low self-esteem is considered to obstruct change, firstly because of the feeling of hopelessness it creates within the patients in regards to their ability to change, causing them to devalue their treatment. Secondly, it pushes patients to adamantly strive to achieve their goals, which in their case comprises of gaining control over their bodies and their eating, which makes change an even bigger obstacle. Core low self-esteem perpetuates a vicious cycle; considering that these patients are already known to have negative cognitions about their selves, anything that they view as a failure, confirms their beliefs that they in fact are the failures, adding support and reaffirmation to their negative-self view. The authors predict

that improving the patients' core self-esteem would be a major factor in improving their overall health.

Fairburn, Cooper, and Shafron (2003), continue by exploring the "mood intolerance" mechanism that occurs in a subgroup of patients with eating disorders. Although adverse mood states were addressed in the original cognitive behavioural theory as being a trigger of binge eating, the current theory believes that this condition is a significant component of the disorder, needing to be specifically addressed through treatment. When dealing with "mood intolerance," patients are unable to handle intense emotions, mostly adverse ones such as anger, but at times their intolerance can encompass even positive moods such as excitement. In order to deal with these changes in mood, they may take part in "dysfunctional mood modulatory behaviour," meaning that instead of accepting the changes they choose to commit excessive and self-harming acts, in order to reduce their awareness of the mood and related thoughts. In attempts to neutralize these mood states, patients may resort to harmful behaviours such as self-mutilation, substance abuse, bingeing, purging, and excessive exercise. Therefore, it is common for patients with eating disorders who suffer from "mood intolerance," to particularly engage in behaviours such as self-induced vomiting, purging, and over-exercising in order to cancel out their intense moods. It is believed that these patients are both susceptible to the intense mood states and are also particularly sensitive to them, therefore causing them to be more of a challenge. The patients' cognitions cause a vicious cycle which serves to perpetuate matters; the mood states occur, causing them to feel unable to deal with the related thoughts and feelings, therefore enhancing the magnitude of the original mood.

The final and seemingly most influential of the four maintaining mechanisms is “interpersonal difficulties.” This new cognitive behavioural theory for eating disorders differs greatly from the previous one, because the latter neglected to take into account patients’ circumstances for the most part. In fact, the research suggests that interpersonal psychotherapy, when used as the sole method of treatment for Bulimia Nervosa, is as effective as Cognitive Behavioural Therapy in the long-term (Agras, Walsh, Fairburn, Wilson & Kraemer, 2000). There are four main reasons why interpersonal difficulties play such an influential role in the maintenance of eating disorders. The first one is that when familial tensions are high within the household, patients (particularly younger ones) may feel the need to assert control, and considering that the body and food consumption are of the few things that individuals have power over, they gain self-control through dietary means (Fairburn, Shafran, & Cooper, 1999; Levens, 1995). The second reason is that certain patients live in homes where the family environment is conducive to worrying about body image due to other members suffering from the same problems, or occupations and ideals that call for the idealization of thinness. The third reason is that negative interactions can trigger binge eating states, seeing as it is grounded in the literature that patients with Bulimia have the tendency to be particularly sensitive to social interactions (Steiger, Gauvin, Jabalpurwala, Seguin, & Stotland, 1999). The fourth and final reason is that when interpersonal difficulties persist for a significant period of time in patients’ lives, it takes a negative toll on their self-esteem, causing them to feel a loss of control, resulting in them pushing even harder to regain it and feel in command of their eating behaviours and, subsequently, their body shape. In addition to the four reasons why interpersonal difficulties play such a crucial role in the maintenance of

eating disorders, it is also relevant to note that it is predicted that patients who are having interpersonal difficulties, often respond poorly to treatment (Agras, Walsh, Fairburn, Wilson & Kraemer, 2000). It is believed that working therapeutically through an individual's interpersonal difficulties can help her to overcome them. Linking Landy's role theory (Landy, 2008), particularly his role profiles (Landy, Luck, Conner & McMullian, 2003) to this process will be beneficial in helping it to move forward. It will allow for the patient to become aware of the roles she plays, the roles she is perceived in, and the roles she wishes to play. This process can be especially cathartic for those who lost much of their youth and adolescence to the eating disorder (Fairburn, Cooper & Shafran, 2003). In addition, working through these interpersonal difficulties through the use of role, will positively enhance their self-esteem and self-evaluation, giving them a sense of control in the domain of their social lives, allowing them to relinquish the need to control their eating, body shape, and weight (Fairburn, Cooper & Shafran, 2003).

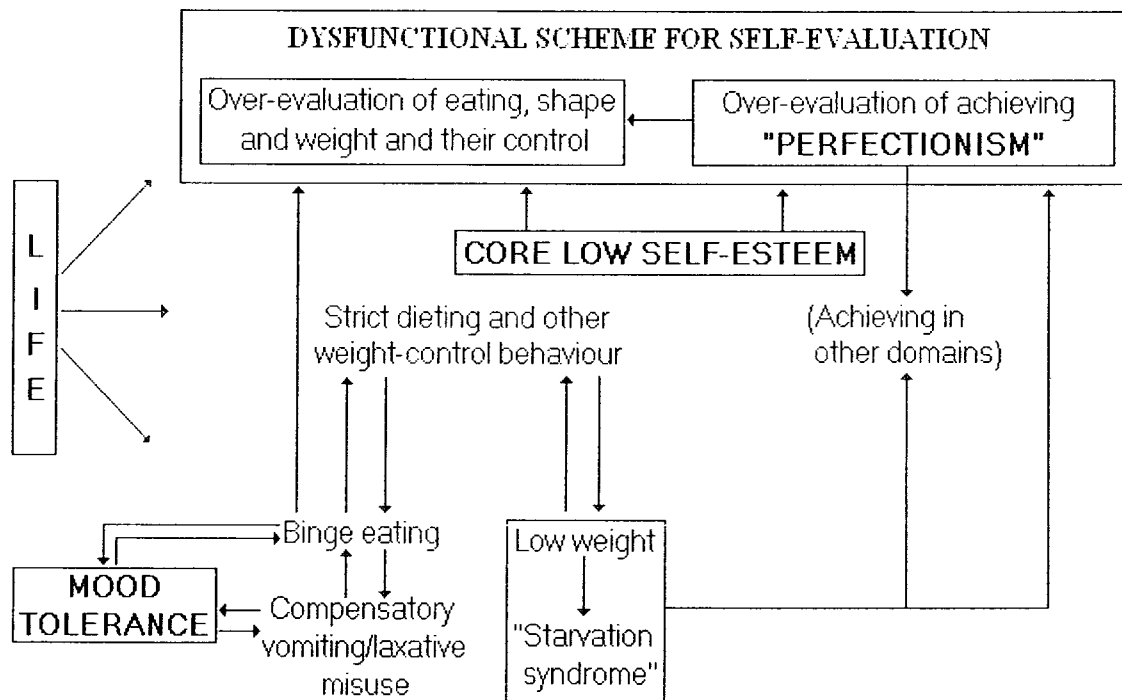
Table 2. Fairburn, Cooper and Shafran's (2003) four maintaining mechanisms.

Maintaining Mechanisms	Description
Clinical Perfectionism	<ul style="list-style-type: none"> • “Over-evaluation of the striving for, and achievement of, personally demanding standards, despite adverse consequences.” • System for self-evaluation: self-worth is based on strive and achievement of demanding goals. • Interaction between perfectionism and attempts to control eating/weight/shape. • Interaction between perfectionism and performance at school/work/sports. • Fear of failure • Consistent and specific attention to performance. • Self-criticism based on negative bias of self-performance.

	<ul style="list-style-type: none"> • Self-criticism translates into negative self-evaluation causing more determination to succeed at goals (control over body), therefore helping to maintain the eating disorder. <p>* suggested that correcting this mechanism may help remove other factors that maintain the disorder, therefore creating change.</p>
Core low self-esteem	<ul style="list-style-type: none"> • Global negative view of self (different from general self-criticism/negative self-evaluation that occurs in Bulimia Nervosa due to failure to achieve goals) • Unconditional and pervasive negative view of self that becomes part of permanent identity. • Negative self-judgments are independent of performance: less affected by changes in the state of the Eating Disorder. • Stands in the way of change in two ways: 1) creates hopelessness about ability to change and undermines the fulfillment of treatment. 2) causes increase in determination to pursue goals (control of eating and body) • Self-perpetuating state <p>* Predicted that if core low self-esteem were corrected, it would result in improvement of patients' outcomes.</p>
Mood Intolerance	<ul style="list-style-type: none"> • Inability to appropriately handle intense mood states; both adverse and positive ones). • Patients take part in “dysfunctional mood modulatory behaviours” to reduce and neutralize awareness of mood state. • “Dysfunctional mood modulatory behaviours” can take two forms: 1) self-injury – instantly lessens mood state 2) psychoactive substances – directly changes mood state. • Binge eating/purging/intense exercise can become habitual behaviours to modulate moods. <p>* Vicious cycle: patients worry they can</p>

	not handle feelings/thoughts resulting from mood change, thereby intensifying the mood state.
Interpersonal Difficulties	<ul style="list-style-type: none"> • Family tensions contribute to resistance to eating resistance. • Certain interpersonal environments enhance pressure about body shape. • Adverse interpersonal situations instigate binge eating episodes. • Undermines self-esteem in the long-term, causing greater desire to meet goals concerning the control of eating/shape/weight.

Figure 1. Diagram of Fairburn, Cooper and Shafran's (2003) transdiagnostic theory of the maintenance of eating disorders. They used 'LIFE' as a short form for interpersonal life.



Fairburn, Cooper, and Shafran (2003), reiterate that the four mechanisms are not necessarily all simultaneously present in each patient, but that when their presence, whether individually or an amalgamation of them, causes the continuation of the eating disorder, they suggest the following treatment plan which will be loosely followed as the

cognitive structure of the proposed Drama Therapy intervention program. The structure of the treatment in the article is based on an ongoing research trial, but for the purpose of this paper, the focus will be on the shorter time frame given, which is for patients who are not considered to be significantly under weight, which is the majority of the cases. On that note, the duration of treatment consists of twenty individual sessions over the course of twenty weeks, but initially beginning with two sessions per week. The first stage of this treatment lasts for four weeks, during which time patients are educated about their disorder, attempts are made to engage them in the process, a therapeutic alliance is formed, and dysfunctional behaviours are addressed and worked on. The second stage of treatment, which is one to three sessions, is used to acknowledge the progress made to date and the acknowledgement of any obstacles standing in the way. But most importantly, an assessment takes place to determine which of the four mechanisms are at play within the patient, and to what extent. Together the therapist and patient may then formulate a plan to address these mechanisms. The third stage, which is a large portion of the treatment, deals with the alteration of the patients' eating disorder psychopathologies such as their perceptions of their bodies, their eating behaviours and the control that they yearn for in this domain. Also during this stage, the identified mechanisms are addressed and worked through. The fourth and final stage, during which sessions will take place bi-weekly, is comprised of the maintenance of recovery once the treatment has been terminated, which is similar to the aforementioned CBT for Anorexia treatment (Cooper, Fairburn, 1984), which was based on the original CBT for Bulimia treatment Fairburn, Marcus, & Wilson, 1993). The final section of this paper will employ the structure of this transdiagnostic treatment and apply a drama therapeutic approach, in hopes of

maximizing the benefits of a cognitive intervention through the addition of an emotionally-based one.

Matto (1997) supports the idea of integrating treatment approaches and further explains that CBT's one limitation is that if it is used as the sole method of treatment, it can potentially draw focus to the intellectual components of the disorder, therefore neglecting to explore the emotions that are involved. She therefore proposed an integrative approach to treating women with eating disorders. This was done by using both CBT and art therapy. The art would allow for patients to express their emotions creatively, helping to balance the cognitive work, and therefore making the therapeutic experience more complete for the patient. The mixture of CBT and art therapy served as a bridge to both therapist and client in a way that neither approach, standing alone, could have. Drama Therapy, of course, will deal with the body in action, bridging its strengths with those of CBT to create a well balanced treatment.

Creative Arts Therapies

Creative Art Therapies is the use of therapeutic interventions through creative mediums such as art, music, dance-movement, and drama. By allowing the individual to express herself through creative avenues, the whole body has the potential to become active, which may help the client to engage her material in new and inspirational ways. In Matto's (1997) application of an art therapy approach to eating disorders, it was found that through artwork, clients were able to express their issues and begin a dialogue with the therapist about some of their maladaptive beliefs. One technique of particular importance was the use of drawings of client bodies compared to actual tracings, which

allowed clients to physically see these differences from a distanced perspective, allowing for discussion.

Levens (1995), as previously noted, describes a re-occurring and consistent way of thinking within the mind of patients with eating disorders; she writes that these patients feel the need to be separate and distanced from objects or people that may lead to danger through contact. In order to maintain this safe distance, Levens suggests that they create extra boundaries between themselves and these objects. One way that Creative Art Therapists can create boundaries and distance, is through projective techniques, such as ones used in Drama Therapy (Landy, 1983).

Drama Therapy

Drama Therapy involves a client working through her issues in a dramatic form, through a variety of different techniques with the group and/or the therapist (Jones, 1996). Jones, an innovator in the field of Drama Therapy, writes that drama therapeutic techniques can be used to help cope with a variety of difficulties. There are a wide variety of expressive forms that a client can use when in Drama Therapy; to name a few of the techniques, clients can engage in their difficulties through projective work using objects, small toys, masks, and puppets (Jones, 1996). A major component of Drama Therapy is dramatic projection which Jones believes "...lies at the heart of all Dramatherapy" (Jones, 1996). This concept will be defined at this point to help explain how certain techniques such as the creation and use of masks or role, can be therapeutic for patients with Anorexia. Projection of one's feelings onto another is a very common occurrence. The person does not necessarily have to be conscious of this action, in fact most times people project their fears, feelings and

opinions onto others subconsciously (Jones, 1996). Drama Therapy takes projection, which can sometimes be a negative attribute, and turns it into a healing process. Dramatic projections occur through role and play with objects, and aid clients to become aware of existing, though sometimes dormant, issues in their lives. Once a participant finds a healthy and appropriate amount of distance, she will be able to project onto a character or object and experience her personal materials. Finally, projection also allows for second chances since it allows for the opportunity to create a new and more preferable ending to unfavourable events or issues. Dramatic projection is the process of placing one's personal experiences and emotions onto an enactment or dramatic technique such as masks, puppets, play with objects, storytelling, photography and make-up. This placement allows the individual to externalize her inner conflicts, thus creating a relationship between her inner self and external form (Jones, 1996). One of the key factors in being able to fully experience the benefits of projection is distancing.

Distancing, a therapeutic concept, is unique to Drama Therapy and is contingent upon the success of dramatic projection. Drama Therapy techniques, as well as the manner in which they are experienced by patients, can take three forms; distanced, underdistanced, and aesthetically distanced (Landy 1997). If a client is too distanced from her material, it may be difficult for her make the necessary drama-life connections (Jones, 1996), meaning that she will have difficulty emotionally connecting to it and relating it to her work because she is keeping it at arms length. On the other end of the distancing continuum, a client can also be underdistanced from her material, meaning that she is unable to gain perspective because she is too close and

the emotional intensity is too high. It therefore disallows her to access any of her underlying issues. The desired and ideal middle ground sought by patients and therapists is called aesthetic distance. Aesthetic distancing allows the client to be both observer and participant within her role, meaning that in relation to her material, she is removed just enough to gain insight and perspective; the drama therefore helps her to achieve psychological growth and change (Emunah, 1994). However, Landy (1997) states the use of distancing will change depending on the client's needs and the flexibility of the dramatic technique with which it is being associated. One patient may need to feel very distanced from a role in order to feel safe and project onto it, whereas another might need to feel a closer link between herself and the role, in order to allow her to associate with it.

Jones (1996) states that projection allows for drama to take on an individual's qualities and then further explore these qualities through the dramatic mediums of masks, role, puppets or play with objects. However, in order to access the full experience of dramatic projection, the participant has to feel safe within the session. In Drama Therapy, it is crucial for one to feel protected from "real life" and its harmful agents. Snow (2000) further explains this by writing, "The metaphorical and poetic world of the tales can serve as a safe container for the chaotic emotional experience of one's 'real life.'" Snow's quotation, although in reference to myth and fairy tale, can still be applicable to Drama Therapy in general. This 'container' leaves out judgment and all other harmful factors that in other circumstances might impede an individual's freedom of expression. Once feelings are projected into this safe container, any necessary changes can then occur. Once the participant "can transform the mode of the real into that of the ideal, fearful, or

fanciful” (Landy, 1986), she can exit the container with a feeling of resolution or accomplishment.

The aim of this past section of the paper was to provide a working understanding of the use of Drama Therapy as a treatment intervention. In understanding how the techniques can be cathartic for clients, one can have a better sense of why and how Drama Therapy would be an effective intervention for patients with Anorexia Nervosa. The following section contains examples from the literature of how Drama Therapy has previously been used with eating disorders.

Wurr and Pope-Carter (1998) used Drama Therapy techniques with a group of adolescents with eating disorders and found that certain distant Drama Therapy techniques such as journey metaphors were very useful. They noted however that techniques emphasizing physicality, involvement of the whole-body, and social interaction, could potentially be very helpful to eating disorder patients, but when used too quickly or insensitively, could, on the other hand, be counter-productive to the therapeutic process. Hinz and Ragsdell (1990) also struggled with the Drama Therapy application when they used masks and video in group psychotherapy, believing that there is an association between a mask representing a part of one’s self that is not usually expressed, and the Bulimic patient who struggles with the concept of real-self versus presented-self. Hinz and Ragsdell hoped to address this inner conflict by having the masked-self ask questions on videotape, to which the unmasked self would later respond. Once the activity had been introduced and started, attendance dropped significantly and continued to do so throughout the process. Some patients expressed that they felt uncomfortable with their appearance and voice on the videotape. The authors

hypothesized that perhaps the construction of masks made the women feel that their inner-selves, which normally remained hidden, would be exposed and this posed a threat to them. Although both mask and videotape are considered to be a part of the Drama Therapy repertoire, with this population they were used in a manner that felt unsafe to the participants, which is why there was such a high attrition rate. A greater level of distance was required for this projective technique; perhaps placing the mask on the therapist/group member and directing that individual in movement and tone. Physically moving away from the masked self, would take off the pressure of overexposing one's self. Although these techniques were not well received, the use of Drama Therapy with this population, when used in a safe manner, could be very effective. For instance, it is suggested in an article using an integrative approach of Creative Arts Therapies and verbal psychotherapy when working with body image issues (Kaslow, Eicher, 1988), that movement while embodying one's mother, followed by repeating the same action but this time as one's self, allows the person to feel that she is in fact an individual; the differentiation will help to develop a sense of her own body (Wooley & Wooley, 1985; as cited in Kaslow & Eicher, 1988). The authors also suggest other Drama Therapy related avenues such as relaxation training (helping participants to release tension and reduce stress), sensory awareness explorations (helping recognize the feelings and impulses that come from within), mirroring (providing the chance to see one's self as reflected through another, which deemed by Winnicott (1971) as imperative in a child's development and self image, can potentially act as a reparative measure if it was not received in the early mother-child relationship), and projective art work, among others. Wurr and Pope-Carter (1998) conducted a Drama Therapy group for adolescents with eating disorders. They

adapted an approach that had previously been used with adults, and geared it more towards the needs of this younger age group. The focus of the group was to create a journey metaphor, and this task was initiated through a combination of guided imagery and Lahad's (1992) six-part story, which is often used in Drama Therapy to assess a client's coping mechanisms, stressors, and conflict areas. Clients were asked to consider that they were about to engage in a journey, and were then guided by six questions. The questions were based on the elements of a fairy tale, which as Von Franz (1987) explains, reflect archetypes of human narrative experience. Following the guided imagery, clients were asked to draw the six parts of their story. Through the sharing of their individual journeys, the group collaboratively used elements of each story to create a unanimous one. The clients then used miniatures (small dolls) and objects to create a structure and place "themselves" in it. Throughout this process clients were able to generalize about the journey metaphor and make the drama-life connections (Jones, 1996), whether it was about family problems, or an eating disorder. As the sessions progressed, the group built a barrier and then creatively found ways to go over or through it, symbolically representing their ability to get past personal obstacles. The final sessions consisted of role-playing, problem solving, and the 'magic shop' (Liebman, 1986; as cited in Wurr, Pope-Carter, 1998; Emunah, 1994; Blatner, 1996), where negative personal attributes were traded in for positive ones. These techniques helped the adolescents to explore new parts of themselves and manners in which to deal with difficult situations. Essentially, this process illustrates that projective techniques help to externalize inner difficulties, making it difficult to deny them and, consequently, challenge people to deal with them (Doktor, 1992). The literature suggests that when used appropriately, and at the right

pace, that Drama Therapy techniques can be beneficial to the treatment of eating disorders. A related field, psychodrama, has also been known to have positive outcomes in terms of embodying feelings as a means of working through them.

Psychodrama

Psychodrama was developed by Moreno in 1934, and is more commonly used to explore specific issues (Jennings, 1981; Jones, 1996). There are similarities in Drama Therapy and Psychodrama in the way that they both use dramatic enactments and role (Blatner, 1996; Jones, 1996). Drama therapists often employ the use of psychodramatic techniques as a way to approach material in an underdistanced, more aggressive manner. In Hamamci (2006), the example of combining Psychodrama's role-playing/empty chair technique with CBT's Dysfunctional Thought Records technique is given to show how the two approaches complement each other. Hamamci explains that the role-play can be used to enact the situation on the patient's Dysfunctional Thought Records. The therapist can use this role-play to alter the negative moods, thoughts and dysfunctional behaviours presented. The most poignant example of how psychodramatic and cognitive behavioural techniques aid each other in reaching a common goal, is the use of the empty chair. This technique helps demonstrate a cognitive concept more clearly (Hamamci, 2006). To reiterate Levens's (1995) argument, a patient with an eating disorder feels unable to affect things around her, and often times feels as though she has no 'voice' within the constructs of a family. This makes the patient feel invisible and affects her potential to have any effect on others. The patient therefore takes control of the one thing that she can, that others cannot, her body. The empty chair technique can allow the patient

to regain her voice. The patient is given control to place whomever she wants in the other chair(s) and is then given the opportunity to confront that individual. This allows for the patient's cognitions to be illustrated in a more concrete fashion (Hamamci, 2006).

Model Program Design

The following section is the construct that has been created based on the literature discussed throughout the course of this paper. The needs and psychopathologies of patients with Anorexia Nervosa have been laid out, as well as the treatments that have been of value in their recovery process. The intention of the following construct is to provide a treatment plan for adolescent girls between the ages of 13 and 17. The structure of this program will follow that of the cognitive behavioural transdiagnostic theory (Fairburn, Cooper, & Shafran, 2003), for which the duration is 20 weeks. In the stages that address the four maintaining mechanisms, in the modified CBT treatment for eating disorders, Drama Therapy techniques will be employed to help create a well rounded approach. As previously mentioned throughout the course of this paper, Drama Therapy and CBT have the capacity to complement each other, creating the opportunity for patients to reach optimal results, both intellectually and emotionally.

Table 3. Model Program Design

		Cognitive Behavioural Approach	Drama Therapy Approach
Stage 1	Session 1	<ul style="list-style-type: none"> • Psychoeducation about disorder • Attempts to engage patient in process • Therapeutic alliance is formed 	<ul style="list-style-type: none"> • Magic Box at beginning and end of each session

		<ul style="list-style-type: none"> Dysfunctional behaviours are addressed and worked on <p>* Sessions one through four share this agenda.</p>	<p>* Used at the beginning and end of sessions 1 through 20</p>
	Session 2	*	*
	Session 3	*	*
	Session 4	*	*
Stage 2	Session 5	<ul style="list-style-type: none"> Acknowledgement of progress Acknowledgement of obstacles Assessment to determine which of the four mechanisms are at play, and to what extent Together the therapist and patient formulate a plan to address the mechanisms. <p>* Sessions five through seven share this agenda.</p>	<ul style="list-style-type: none"> Narrative: Letters to self Six part story (Lahad, 2000)
	Session 6	*	
	Session 7	*	
Stage 3	Session 8	<ul style="list-style-type: none"> Alteration of patient's eating disorder psychopathologies (body shape perception, eating behaviours, desired control in this domain) Identified mechanisms are addressed and worked through. <p>* Sessions eight through 15 share this agenda.</p>	<ul style="list-style-type: none"> Collage part #1
	Session 9	*	<ul style="list-style-type: none"> Collage part #2
	Session 10	*	<ul style="list-style-type: none"> Mask making part #1
	Session 11	*	<ul style="list-style-type: none"> Mask making part #2 - Interaction of masks
	Session 12	*	<ul style="list-style-type: none"> Relaxation training
	Session 13	*	<ul style="list-style-type: none"> Narrative-Empty chair
	Session 14	*	<ul style="list-style-type: none"> Role Profile (Landy, Luck, Conner, McMullian, 2003)
	Session 15	*	<ul style="list-style-type: none"> Role Play
Stage 4	Session 16	<ul style="list-style-type: none"> Maintenance of recovery <p>* Sessions 16 through 20 share this agenda.</p>	<ul style="list-style-type: none"> Preparation for termination through re-cap of treatment Drama-life connections are explored <p>* Sessions 16 through 19 share this agenda.</p>

	Session 17	*	*
	Session 18	*	*
	Session 19	*	*
	Session 20	*	• Termination- Letter of advice

Magic Box

The magic box (Emunah, 1994) will be pulled down by the therapist and client at the start of each session as a form of checking in. The client will be asked to place in the box something (figuratively) that they do not wish to carry with them (also figuratively) for the duration of the session. The box will then be sent back up and summoned back only at the end of the session. At this point, the client will be asked to take something from the box that she feels she has gained. This process will occur throughout the course of treatment, allowing the therapist to check in with the client before and after each session to get a sense of what she is feeling, to gauge her progress, and to create a ritual and frame around the sessions.

Narrative: Letters to self

The client will be asked to write three letters: the first one as her past self, the second one as her present self, and the third one as her future self. The therapist will ask the client to address, in each letter, the progress made and the existing challenges. Once all three letters are completed, the client will be asked to read them out loud. The past, present, and future progress and challenges can be further discussed at this point. The letters help the therapist to assess which mechanisms the client is dealing with, and to what extent, as well as to warm the patient up to expressing her inner feelings and acknowledging her progress as well as the work still ahead.

Six-Part Story

Lahad's (1992) six-part story is an assessment technique to help determine a client's coping strategies as well as her stressors and conflict areas. The client is asked to divide a sheet of paper into six boxes, and in each box she is asked to draw the following:

box 1- The main character of the story

box 2- What is the character's mission?

box 3- Who/what can help the main character to accomplish this task (if at all)?

box 4- What obstacle stands in the way of completing the mission?

box 5- How does the main character deal with this obstacle?

box 6- What is the outcome? How does it end?

The therapist will then look for configurations and reoccurrences within the BASIC PH

(Lahad, 1992)

Belief

Affect

Social

Imagination

Cognition

Physical

Once again, this process will give the therapist the opportunity to assess which mechanisms need to be focussed on throughout the remainder of the treatment. Seeing as how the six-part story is a projective technique, the client's subconscious may come into play, resulting in an authentic self-revelation.

Collage

Assuming that the client suffers from all four maintaining mechanisms, they will each be allotted two sessions. The collage will be used to address clinical perfectionism. The client will be asked to create a collage as a means of introducing herself. She will have magazines and art supplies at her disposal. Matto (1997) argues that art can help make order out of chaos by containing the mess. This process is particularly beneficial for perfectionists because it allows them to gain control and mastery in a domain other than food. The second session will be devoted to completing the collage and then discussing the final product. This will allow the client to be faced with her high self-expectations and allow her to possibly create, with the therapist's help, more realistic ones. The client's body image and control issues will also likely arise through the collage.

Mask Making

The two sessions allotted to mask making will be associated with the "core low self-esteem" mechanism. In the first session the client will be asked to create two masks that are opposite from each other. Being that mask making is a projective technique (Jones, 1996), the client will be able to project two different sides of herself onto them throughout the creation process as well as in their usage. In the second session, the client will be asked to name each mask and place them in relation to each other within the room (Y. Silverman, personal communication, February 21st, 2008). The client will then introduce each mask to the therapist and share something about them, as well as say her own name and something about herself. The client's introduction of self amongst that of the masks will help create an aesthetic distance (Landy, 1997) from which she can learn from her material, rather than becoming emotionally overwhelmed by it. By not wearing

the masks and introducing herself as well as them, she will maintain a sense of distance, allowing her to experience her material, also avoiding attrition such as occurred in Hinz and Ragsdell's (1990) group, which was possibly due to the clients being underdistanced with their masks. The next step will be for the client to think of a line that each mask would say to the other. She will then have the masks begin a dialogue, beginning with those lines, and continuing through improvisation. This technique will enable the client to see different parts of herself, as opposed to solely seeing her negative sense of self which she normally focuses on. The dialogue between the two masks will give her the opportunity to vocalize her internal struggle and, hopefully, gain a sense of resolution.

Relaxation Training

This technique will take place during the first of two sessions allotted to the "mood intolerance" mechanism. The client will be asked to lie down on her back. She will then be guided, by the therapist, to become aware of her breath, her body parts, and areas in which she feels tension (the therapist may embellish on these instructions). The client will then be guided through a clenching and releasing of her body parts (starting from the toes and working up to the head), while inhaling for tensing and exhaling for releasing. Once the body parts have been addressed, individually, the client will collectively tense and release her body three times while continuing to focus on her breathing. In her own time, she will bring herself to her feet. She will then journal about how she feels, and proceed to share the entry with the therapist. This process will teach the client calming strategies that she will be able to use when faced with adverse mood states.

Narrative – Empty Chair

In the second session dedicated to working on “mood intolerance,” the client will be asked to write a letter to a person or about a situation to whom/for which she experienced an adverse mood. The writing process will allow the client to externalize and direct her internal feelings, avoiding the displacement onto food, shape, and weight. This process may help her to name her triggers, and understand where they came from and why. Once the letter has been written, she will be asked to figuratively place the person/people/object in an empty chair(s), and then proceed by reading them the letter. Reading the letter provides the adolescent with a safety net because it alleviates the pressure that improvisation sometimes entails. Conjuring up those feelings may be a difficult task, and will be better achieved with time to reflect. The client will then be asked to reverse roles with the person in the chair, and give herself a response, as that person, and saying what she thinks that person would say. This role reversal will allow her a second chance (Jones, 1996) to have a more favourable outcome than she did the first time around, leaving her with a sense of resolution and accomplishment.

Role Profile

Role profiling (Landy, Luck, Conner & McMullian, 2003) will be the technique used in the first of the two sessions devoted to the “interpersonal difficulties” mechanism. In order to repair an individual’s relationships with others, it is important to first work on one’s relationship with herself. Every person plays a number of roles in everyday life. Due to the psychopathology of a patient with an eating disorder, it is possible that she will have a dysfunctional self-concept, forcing her to remain trapped in negative roles. The client will be given the list of roles from Landy, Luck, Conner and McMullian’s

(2003) role profiling technique, and asked to place them in the four categories: “This is who I am,” “This is who I am not,” “I’m not sure if this is who I am,” and “This is who I want to be.” Once this process has been completed, the therapist will ask the client questions such as whether or not any of her placements surprised her, upset her, took a long time, or took no time. The discussion of this process will help the client to figure out the roles she plays, and the ones that she would like to add onto her role repertoire (Moreno, 1934). This understanding of self can in turn help her to better connect with others.

Role Play

Improvisational role play is used in the final session addressing “interpersonal difficulties” in order to work through problems in interpersonal communication that the client may be experiencing. It will be up to the client to present relationship scenarios that she would like to play out with the therapist. These enactments and role-reversals will help the client to gain perspective on how she can better express herself in order to attain better interpersonal relationships.

Letter of Advice

As part of the termination process of the final session, the client will be asked to write a letter of advice to herself, to which she can return if faced with difficult times in the future. She will be asked to summarize her strengths that she discovered through the course of the treatment, five of her positive attributes, and advice that she would give to someone in her past situation who is faced with wanting to overcome an eating disorder. If there are additional things that the client feels are important to add to her letter, she

may do so. She is instructed to seal the letter in an envelope and have it read her name, as well as “read when needed.” This final letter will help the client to remember her accomplishments over the last 20 sessions and to see how far she has come. The letter will serve as both a transitional object, helping her to make a smooth switch from therapy to ‘real life,’ and as a source of inspiration and support for the future.

Conclusion

The literature review explored Anorexia Nervosa in terms of its aetiology, its psychopathologies, and its treatments. Patients’ and therapists’ views on the necessary components of treatment were noted, and studies and articles were reviewed to assess their successes as well as their pitfalls. There was a common trend throughout the literature when looking at Anorexia, and that was the use of Cognitive Behavioural Therapy as a treatment intervention for it. Although CBT’s strengths were clearly presented, it was also noted that the sole use of CBT may over intellectualize the treatment of the disorder and prevent the client from exploring the emotions that are at the root of her psychopathologies (Matto, 1997). Drama Therapy, a form of psychotherapy that uses dramatic projection to help bring a client’s material to the surface, is proposed as a useful complement to Cognitive Behavioural Therapy in the treatment of Anorexia Nervosa. The suggested program design is aimed at offering adolescent patients the opportunity to fully explore themselves throughout the course of treatment. A fairly recent Cognitive Behavioural Theory for the treatment of eating disorders, which addresses four potential mechanisms found in patients (Fairburn, Cooper & Shafran, 2003), creates the perfect structure to which Drama Therapy techniques can be applied to create a well rounded and integrative approach.

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