

TAKING UP SPACE:

A Case Study Exploration of the Combined Use of Kinesphere and Scenework in
Therapy for Adolescents with Anorexia Nervosa

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ABSTRACT

Taking up Space: A Case Study Exploration of the Combined Use of Kinesphere and Scenework in Therapy for Adolescents with Anorexia Nervosa

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The following is a descriptive exploration of the therapeutic process of a group of five adolescent girls suffering from a restricting-type eating disorder that I worked with for six weeks in the context of a drama therapy internship. The study aims to describe the combined use of the concepts of kinesphere and scenework to meet therapeutic goals. The kinesphere is the amount of space that can be reach by one's body and that makes up the notion of one's personal space bubble. This idea was combined in short, semi-improvised scenes to address some of the main issues faced by clients with anorexia nervosa; namely, the impaired relationship with one's body and its interaction with social relationships.

The paper uses the perspective of impaired family and social relationships, distorted body-image and self-objectification, and internalization of emotions to describe the presentation of anorexia nervosa. Theoretical as well as empirical support is presented for the use of dance/movement therapy and drama therapy techniques to address these main issues and a description of the group's progress through the six-week process is presented.

The goal of this research is to gain a better understanding as to how drama therapy and dance/movement therapy can be used in combination to potentially better address the pervasive symptoms of anorexia nervosa.

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Introduction

My internship during the second year of drama therapy training was as part of the eating disorders team of a children's hospital. As part of this internship, I was tasked with offering individual drama therapy sessions to young girls with eating disorders who were referred to me by the medical staff. These young girls were between the ages of ten and seventeen. They suffered from a variety of symptoms and were at different stages of illness and recovery. Therefore, I was exposed to a variety of cases within the eating disorders category.

As well as drama therapy training, I have been concurrently training as a dance/movement therapist and have incorporated some of these methods and concepts in my sessions. In dance/movement therapy training, the integration of body and mind are a central focus for well-being. As will be discussed, this integration is especially lacking in the life of a person suffering from an eating disorder where the body is a separate entity to be controlled. Because it is seen as separate, it can also be contextualized as the enemy and becomes the site of punitive behaviours. As such, I found it helpful to integrate body-based dance/movement therapy concepts with my drama therapy work in my sessions with these young girls.

Affordable therapeutic resources for eating disorders currently seem lacking for the amount of demand. As the hospital had a waiting list of clients waiting for therapeutic services, I was offered the opportunity to work with a few young girls with anorexia nervosa in a group setting as a way of maximizing our limited resources. Group therapy was also an attractive option because of the different benefits that could be

gained through peer interaction rather than individual sessions. I decided to also take this opportunity to record the group's process and reactions to the combination of specific dance/movement therapy and drama therapy techniques. As a preliminary inquiry, my hope is that the concluding observations will lead to a better understanding of the use of the kinesphere and scenework with adolescents suffering from anorexia nervosa and that it will prompt further research on the topic.

This exploratory case study began from a constructivist, information-building philosophy of research. The conclusions of the report seek understanding rather than explanation (Stake, 1978). The constructivist paradigm sees understanding as equally important to explanation. Lack of empirical generalizability is one of the perceived weaknesses of the case study, however, Stake (1987) argues that this methodology provides naturalistic generalizability because it appeals to the subjective experience of the reader:

Naturalistic generalizations develop within a person as a product of experience. They derive from the tacit knowledge of how things are, why they are, how people feel about them, and how these things are likely to be later or in other places with which this person is familiar. They seldom take the form of predictions but lead regularly to expectation. They guide action. (Stake, 1978).

Naturalistic generalizability can play an important role in practice-based research where the reader is often a practitioner who benefits from a full description of context and nuance, which he then relates to his own past or current experiences with clients. This may partly explain why research in the creative arts therapies utilize the case study method as a way to describe the process of therapy within its context (Doktor, 1991; Hinz

& Ragsdell, 1990; Radmall, 1997; Silverman, Smith, & Burns, 2013). The exploratory case study's focus on understanding can provide important information that highlights areas for further inquiry, that guide action, and that help build theory in research fields that are less understood (Stake, 1987; Yin, 1994). In this case, the interest lies in understanding how particular combinations of drama therapy with dance/movement therapy might impact the therapeutic process of adolescent girls with anorexia nervosa.

Theories on Anorexia Nervosa

Eating disorders have been a topic of increased focus in western society over the last hundred years. Anorexia nervosa, in particular, seems to capture the attention of researchers, medical professionals and the media. This might be partly due to the universality of the experience of eating and the physical and psychological distress that hunger causes for most normally developing mammals. We are simultaneously alarmed and fascinated by the idea that people would willingly subject themselves to a state of starvation. The severe consequences of starvation also contribute to our interest in understanding this devastating disorder. It has been proposed that anorexia nervosa is the result of a complex interplay of social, developmental, and biological factors. Many theories on the aetiology and maintenance of anorexia have been developed. I have chosen to focus my discussion of anorexia nervosa on social/cultural and developmental perspectives; namely, family dynamics, interpersonal functioning, development of body image, and of emotional states, because these serve to explain the rationale behind my choice of therapeutic intervention and better corroborate what I have observed in individual sessions.

Impaired Family Dynamic and Interpersonal Functioning

One of the earliest and most extensive theories on anorexia nervosa was proposed by Hilde Bruch who spent much of her career as a psychoanalyst working with this population. Bruch (1978) used the metaphor of a sparrow in a cage to describe the person suffering from anorexia. The sparrow that is caged is valued for its beauty and fragility and is kept from fulfilling its true nature. Likewise, the young girl suffering from anorexia believes that she is valued for the image she portrays and becomes trapped in a state of self-imposed control. Bruch observed that most of her patients came from seemingly privileged backgrounds of middle to upper-class parents, were well-mannered and attained a high level of achievement in many areas. One could wonder why a child who seems to have it all can be plagued with such a debilitating disorder.

Bruch (1978) describes similarities that she has observed in her young patients over the years. She claims that the most influential factor in the development of anorexia is the family dynamic. Mothers are described as overprotective or overbearing while fathers seem to be emotionally unavailable or physically absent (Bruch, 1978). There is a tendency from parents to emphasize and value external conditions of worth such as academic achievement, politeness, while simultaneously de-emphasizing the expression of emotions. The result seems to be that the child in this dynamic places extreme importance on self control in order to live up to the expectations she perceives from her parents until the pressure becomes too great. The non-expression of emotions remains the family norm, “until the illness becomes manifest and the former goodness turns into indiscriminating negativism” (Bruch, 1978, p. 32). The child suffering from anorexia will show behaviours of acting out in aggressive and defiant ways, perhaps as a reaction to the family environment (Bruch, 1978). Self-control, will power, and the control of

emotions are seen as highly desirable qualities in this family environment. Food restriction and refusal becomes an extreme form of self-control that, a) distracts the child from experiencing negative emotions, and b) can provide a feeling of pride at having accomplished something that requires will power. Parents (in Bruch's opinion, mothers) are sometimes said to also have a distorted sense of how much their child should be eating because they are themselves concerned about their weight and attempts to diet (Bruch, 1978). Some parents reported that they "envied their child the will power of existing on token amounts" (Bruch, 1978, p. 3). Some patients even report an enjoyment for the feeling of hunger that reinforces their behaviour (Bruch, 1978). This is because the state of starvation has a disorganizing effect on thought processes and causes confusion about physiological sensations (Bruch, 1978).

According to Bruch (1978), the family dynamic places the child in a constant state of fear that they must live up to perceived expectations in order to be loved and accepted. What results is a child or adolescent that is often over-compliant and does not have a clearly differentiated sense of selfhood (Bruch, 1978). Due to this over-compliance, perfectionism, and rigidity, problems are also observed in interactions outside the family circle where they experience self-imposed social isolation (Bruch, 1978). Two explanations for social isolation from peers are given: the first is a fear of rejection due to not feeling good enough, and second is a condescension or distaste for peers in their age group who are perceived as immature (Bruch, 1987). When friendships are present, they are limited to one friend at a time for short periods, where the young patient develops a variety of interests. Bruch sees this as another sign of over-compliance, where the young girl takes on the interests of the friend: "With each new friend anorexics will develop

different interests and a different personality [...] Even a seemingly active social life may be an expression of over compliance” (Bruch, 1978, p. 49).

From the perspective of object relations theory, the problematic functioning of the family creates an impairment in the adolescent’s development of selfhood, which leads to boundary confusion in interpersonal relationships (McIntosh, Bulik, McKenzie, Luty, & Jordan, 2000). The adolescent sufferer has difficulty tolerating the feeling of separateness from others due to the lack of clear personal identity as well as a difficulty tolerating the simultaneous presence of good and bad qualities within one person (McIntosh et al., 2000). There is both external and internal boundary confusion in this case, where the message is, “I do not exist as separate from the other” and “People cannot be good if they are bad.” The concept of boundaries is either one of complete separateness or total fusion, without room for flexibility.

More modern studies have supported the importance of this correlation between anorexia nervosa and interpersonal difficulties. When interviewed about their personal experience of living with anorexia nervosa, the two themes that women most commonly reported were “loss of control” and “relationship problems”, where control of food is used to escape negative emotions caused by interpersonal problems (Button & Warren, 2001). One woman in the study was quoted as saying: “When thinking of food I wasn’t thinking of other problems happening. A way of blocking it out.” (Button & Warren, 2001, p. 82). Compared to other groups of women studied, those suffering from eating disorders have been found to have a higher degree of interpersonal problems (O’Mahoney & Hollwey, 1995). It seems that interpersonal distress could be a contributing factor to the maintenance of the illness. Although there are currently no

studies showing a causal link, there is a correlation between interpersonal functioning and the severity of the illness, where the women with the most interpersonal impairments also seem to have more severe cases of anorexia nervosa (O'Mahoney & Hollwey, 1995).

Development of Body Image and Objectification Theory

One of the main symptoms of anorexia nervosa is a distortion of body image where the individual's perception of herself as overweight or deformed is not supported by reality. Body image is usually defined as the mental representation of one's body. Yet it is also the perceptual experience of the body through the senses where "the formation of this image is based on reception of sensations coming from skin, viscera, muscles; also on a sense of body unity, including awareness of position and posture" (Totenbier, 1995, p. 193). It seems far from coincidental, then, that the symptoms of anorexia nervosa often emerge in adolescence, when major physical changes are taking place, which are experienced both psychologically and physiologically. In order for a fully integrated concept of body image to be crystalized, the *perception* of one's body must catch up to the quick physiological changes in effect. In anorexia, this process is hindered. Understanding how this distortion could possibly take place is important to developing interventions aimed at correcting body image distortions.

The development of body image is *kinaesthetically* and *socially* constructed. The kinaesthetic construction of body image takes place through the sensory experience of one's body moving in space (Dosamantes, 1992). Body image changes as we move in different ways through our environments. From a dance/movement therapy perspective, our environment imposes specific movement patterns that are experienced sensorially, are integrated and contribute to the development of a clear sense of self. Body image is

described as both internal and external; as more than a mental representation of the body's appearance, but as the integrated sense of *being* a body.

The movement experiences that stimulate the outer surface of the body tend to strengthen the sense of our body boundaries, whereas movement that makes use of the center of our bodies allows us to acquire a sense of having a body core [...] furthermore, movement experiences that explore the vertical axis enables us to experience the struggle between being in a safe place and reaching upward toward the unknown, whereas exploring the horizontal axis through movement lets us experience taking in from the outer world and giving out from within.

(Dosamantes, 1992, p. 261)

The quote above stresses the importance of movement and sensation in the integration of experiences. There is no distinction between body and mind because the mind is the brain and the brain is the body. Perception and sensation are seen as simultaneous and reciprocal processes.

In anorexia nervosa, there is a pathological control of the body where sensations are either experienced with confusion (Bruch, 1978), ignored and dissociated from (Vanderlinden, Vandereycken, van Dyck, & Vertommen, 1993), or responded to inappropriately/punitively. There is no integration of body and mind in this situation, but rather, an attempt at controlling physiological states using the mind. The concept of body and mind as separate allows for the body to continue to be a target for punishment and control because there is no sense of the body *as* the self (Chaiklin, Lohn, & Cathcart, 2003; Dosamantes, 1992).

Chaiklin, Lohn and Cathcart (2003) have developed a three part model of body image from concepts of dance/movement therapy. They title these three parts as *image properties*, *body-self* and *body-memory*. The traditional definition of body image as the mental representation of the body's appearance, shape, size, etc. is the first level of image properties. This is the concept of the body as an object that most individuals can perceive about themselves by childhood. The second level of body image is the body-self, which is the sense of being a body or the sense of self. This is the awareness of, or the lived experience of the body. In order to experience this level of body image, one must be aware of physical body boundaries as well as one's personal and interpersonal space. This second level requires a proprioceptive understanding of the size of one's personal space and the way this interacts with the environment. The concept of body-self also involves an awareness of emotions and how they are connected to the body. Incongruent emotional expression, for example, where a person is showing flat facial affect while experiencing emotions of intense sadness could be exhibiting an impaired sense of body-self. The third level of body image is body-memory. This is the concept of the body as the container of past experiences, which "provides the background, or reference point for evaluating current sensations [...] it carries the life that the person has lived and experienced" (p. 52). It is the understanding that the representation of self is shaped by the experiences of the past.

As the young person leaves childhood and enters the early stages of adolescence, she begins to place importance on social circles that are outside of the family group. She becomes increasingly aware of the external gaze of others, which also affect the integration of her body image. Peer groups, media, and in modern society, social media

become powerful forces that influence the development of body image. While physical changes in adolescence happen to everyone, the type of body image distortion present in anorexia nervosa and the illness of anorexia itself afflicts women disproportionately more than it does men. Some theories propose that the societal pressures, expectations, and images of women are at fault for this gender difference.

Objectification theory contends that societal focus on the objectification of women's bodies leads to a process of internalization of social norms and self-objectification in women who suffer from eating disorders (Calogero, Davis, & Thompson, 2005; Fredrickson & Roberst, 1997). Fredrickson and Roberst (1997) argue that media and everyday social representations of women are hyper-focused on the woman's body and often, on the woman's body as a sexual object. This focus is to the detriment of other aspects of the self that make someone an individual. A social and institutional construction is in place where "attractiveness functions as a prime currency for women's social and economic success" (p. 178). Women who are deemed more sexually appealing are socially praised and also receive higher wages and job opportunities. Through a powerful process of socialization, women place importance on physical appearance because it has direct consequences to their success. This societal gaze; particularly the male sexual gaze (Calogero, 2004), is eventually internalized in a process of self-objectification that, "begins with compliance to minimally sufficient external pressures, proceeds through interpersonal identification, and ends with individuals claiming ownership of socialized values and attitudes, often by incorporating them into their sense of self" (p. 177).

This theory reinforces the idea that young girls develop body image as the representation of the body's appearance, shape and size as an object, separate from themselves. Focusing on the appearance of the body allows us to "psychologically distance" ourselves from our bodies; it continues to separate the person from the body (Calogero & Thompson, 2005, p. 43). When bodies are objects, they can more easily be the target of criticism, control, punishment and the source of shame (Fredrickson & Roberst, 1997). The fact that society treats women's bodies differently than men's is a possible explanation for the gender difference in rates of anorexia nervosa.

Research also shows support for the theory of self-objectification affecting women's body image attitudes. For example, Calogero, (2004) found support for the hypothesis that "the internalized male gaze, and not just any gaze, negatively affects women" (p. 19), leading to experiences of body shame and anxiety about physique. This could be a function of the traditional, hetero-normative social pressure for women to be the objects of the sexual fantasies of men. There is also evidence that when asked about themselves, patients with anorexia focus on physical attributes and self-drawings of participants with anorexia show exaggerated, cartoonish versions of self and a rejection of their bodies (Gillespie, 1996).

Internalization

The symptoms of anorexia nervosa persist, in part due to the internalization of negative emotions. It is hypothesized that clients suffering from anorexia nervosa displace negative emotions onto themselves in a punitive way rather than externalizing them through acting out behaviours and communication (Geller, Cockell, Hewitt, Goldner, & Flett, 2000). Perhaps this is a result of the impaired family dynamic

described by Bruch (1978), in which expression of emotion is actively discouraged and perfectionism is encouraged. Consequently, the adolescent with anorexia nervosa develops the thought that the expression of negative emotions is a show of personal weakness and imperfection and expends considerable energy controlling these feelings (Geller et al., 2000), for example, by avoiding body movement (Berger, 1972; Payne, 1995). Research has shown that women with anorexia nervosa suppress feelings of anger and anxiety more than other groups, and avoid conflictual situations by silencing their own feelings while prioritizing the feelings of others (Geller et al., 2000). Without a release, emotions are turned inward, displaced onto the self and emerge in punitive, self-controlling behaviours like food restriction (Bruch, 1978; Geller et al., 2000).

Treatment Approaches

An international study on the prevalence of eating disorders revealed that they occur most often among young women between the ages of 15 and 19, where it is estimated at 0.4% for anorexia nervosa and around 1% for bulimia nervosa (Hoek, 2006). Because complications of these disorders often lead to injury of internal organs, death and suicide (Hoek, 2006), finding effective methods of treatment is important. As of now, all current treatment methods for anorexia nervosa show weak results (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). However, there is some evidence to support the use of variants of family therapy with adolescents (Bulik et al., 2007). Current approaches to therapy are either in inpatient or outpatient care, depending on the severity of the symptoms. The use of medication is commonly prescribed in conjunction with psychotherapy but has shown mixed results: “Although mood may improve with tricyclic antidepressants, this outcome is not associated with improved weight gain.

Moreover, medication treatment for AN is associated with high dropout rates, suggesting that the currently available medications are not acceptable to individuals with AN” (Bulik et al., 2007, p. 317)

There is research support for the use of creative arts methods and most facilities treating eating disorders use at least one form of creative arts therapy as an adjunct method (Bulik et al., 2007; Frisch, Franko, & Herzog, 2006). However, almost all of the research involving creative arts therapies is qualitative or involves a small sample size that makes it difficult to extrapolate results to the general population. Still, research on the use of creative arts therapies with those suffering from anorexia nervosa can help shed light on how these methods are currently being used with this population and what the emerging patterns seem to be.

Drama Therapy

The use of drama therapy with clients suffering from anorexia nervosa is interesting because of its potentially beneficial role in the externalization of emotions. Drama offers a safe space for clients to express themselves where difficult situations can be enacted with the buffer of playfulness and imagination (Jones, 2007; Emunah, 1990). The process of dramatic projection, where “playing with objects or playing roles, connect outer expression in drama with inwardly held feelings or life experiences” (Jones, 2007, p. 83) allows clients to explore difficult emotions and situations with a certain degree of emotional distance. This is especially appealing when working with adolescents who are known to ignore or repress their emotions. Renee Emunah, who has used drama therapy extensively with adolescents, explains that it is an ideal structure for this population because of the combination of freedom and boundaries it provides.

Although their need to express and communicate their internal world is great, they have not yet acquired the capacity to verbally articulate what they think and feel, in the sense of having a meta-level of awareness, in which one can reflect, with some perspective and distance, on one's thoughts and feelings. A form of expression is desperately needed, one which matches the intensity and complexity of their experience, is direct but nonthreatening, is constructive and acceptable.

(Emunah, 1990, p. 102)

Drama feels safe for the adolescent because it allows her to try out behaviours without the threat of consequences. Emunah emphasizes not just the need for cathartic emotional expression, but also the need to gain a sense of mastery over one's emotions. This is because pure catharsis can be overwhelming and does not necessarily lead to insight. By expressing themselves within the structure of roles, characters, scenes, games, etc., adolescents learn to externalize their internal conflicts in a safer and more organized way. She refers to this as the interplay between expression and containment.

With the therapist as director, drama therapy also has the potential to manipulate the client's *distance* to the emotional material that she projects within scenes and exercises (Landy, 1983). Drama therapy techniques can be manipulated on a spectrum between being *under-distanced* and *over-distanced*. An exercise that is over-distanced is described as such because it provides the client with a certain amount of intellectual distance from emotional material (Landy, 1983). This means that the emotional expression will likely be more cognitively experienced than physiologically, which provides safety from overwhelming feelings. Over-distanced exercises will usually be fantasy-based, set in imaginary locations and perhaps using non-human characters so that

they are far from potentially triggering, real-life situations. Under-distanced scenes on the other hand, are much closer to the client's personal emotional material by being reality-based. The therapist can use the spectrum of exercises to manipulate the amount of aesthetic distance necessary for a particular client or group. Since emotions that are too overwhelming are likely to be repressed, the use of distancing can allow for greater emotional expression because it can help the client approach difficult content in a way that feels safe (Landy, 1983).

Knowing that drama therapy is a potentially beneficial treatment option for adolescents, it may also be appropriate for individuals suffering from anorexia nervosa. Bailey's (2012) study is one of the few available resources on the subject and revealed that women suffering from eating disorders who participated in a psychodrama group, self-reported an increase in self-esteem, self-trust and self-acceptance. Participants also reported that psychodrama allowed them to access their emotions and helped them make holistic connections and insights (Bailey, 2012). However, this study is an unpublished doctoral dissertation limited by its small sample size.

A study by Jacobse (1995) explored the use of drama therapy in the treatment of eating disorders and enumerated a series of observations. The behaviours of clients with anorexia were recorded based on four chosen elements of drama therapy: "acting as such," "means of communicating," "role choice," and "functioning in the group."

One the first element of "acting as such," clients with anorexia nervosa were recorded as preferring to be invisible on stage and being as hidden as possible. They were observed to attempt to cover up and try to explain why they had acted in specific ways upon debriefing. Embodiment was minimal and clients preferred to express

themselves verbally. When asked to make body sculptures, clients were observed to create small, rigid “univocal” forms (p. 134) with attempts at being precise. Clients were recorded as preferring real, well-known situations to imaginary ones. Finally, a lack of emotional expression was also observed.

On the second element, “means of communicating,” clients with anorexia nervosa were shown to express themselves verbally but in soft voices and make small, minimal movements. In terms of role choice, participants chose central, caring roles and avoided conflict within the scenes. The author also reported a lack of flexibility in role choice. The clients’ functioning in the group was described as taking control, caring for others, desiring to be loved, and taking responsibilities.

From these observations, Jacobse (1995) generated a few recommendations for drama therapy groups with this population. The author suggests that it is important for clients to develop a role through communication with one another during scenes rather than focusing on the self. To do so, a limited amount of preparation should be done before scenes that include a beginning, a middle, and an end, at which point all clients should take part in distributing the roles. Preparation time should be limited as clients may take too long trying to perfect the scene as a way of delaying the enactment. Jacobse also stresses the important of avoiding rationalizations during debriefing so that clients can be encouraged to experience their feelings (p. 137).

Dance/Movement Therapy and Body-Based Interventions

Dance/movement therapy is used in the treatment of eating disorders by targeting body image distortions through the re-integration of body and mind (Chaiklin et al., 2003; Dosamantes, 1992; Krantz, 1999; Totenbier, 1995). Rather than addressing the

cognitive distortions, dance/movement therapy provides an opportunity for clients to have an expanded sensory experience of their bodies that will hopefully lead to a more integrated sense of self. The main goal is the “clarification of the client’s body image” (Totenbier, 1995, p. 194), one that includes an awareness of, and a response to emotional states. Awareness of physiological states and body boundaries is achieved through touch the sensory experience of the body in movement (Totenbier, 1995).

Central to this approach is the concept of the reciprocal relationship between body movement and personality. An individual’s personality, cognitions and emotional state influences the way they move through their environment, while the sensory experience of moving through the environment also impacts their personality, thoughts and emotions (Berger, 1972; Payne, 1995). Therefore, adjustments to, and expansions of one’s movement repertoire can create changes in the client’s psychological and emotional experience: “A basic assumption is that movement or posture is an important personality component [...] the most direct experience of the self [...] is available through the body; the awareness of the relationship between emotional and primary experience is primary in the approach” (Payne, 1995, p. 210).

Body movement and sensory experience theoretically promote the two higher-level components of body image proposed by Chaiklin and colleagues (2003): body-self, and body-memory. It promotes body-self by providing an experience of the body that includes more than just a mental representation of its appearance; it forces the client to experience the body, perhaps in new ways. Moving one’s body can also initiate the emergence of memories and emotions, promoting the level of body-memory. Both of these experiences are important for clients suffering from anorexia nervosa because they

encourage a more broadly defined and more integrated sense of self as well as help with the release of negative emotions that contribute to the disorder. Dance/movement therapy can serve to assist clients with eating disorders in integrating their psychological, emotional and physiological states by helping them “to recognize feeling states and to reconnect affect to ideation and behaviour” (Krantz, 1999). This approach forces the client to become aware of physiological, psychological and emotional states. Awareness of the interaction between thoughts, feelings and actions, can give clients the opportunity to respond to negative thoughts and feelings in a different way.

Promising support has been found for the relationship between body awareness training and a reduction in disordered eating habits (Daubenmier, 2005). An awareness of bodily sensations combined with training aimed at responding to these sensations seems to promote healthier eating habits in women with disordered eating (Daubenmier, 2005). However, simply moving one’s body is not enough; the type of movement and the associated response behaviour inherent in the movement activity is also an important factor. Specifically, yoga was shown to reduce disordered eating while aerobic exercise showed a much smaller impact, perhaps because of its focus on body fitness rather than positive body sensation (Daubenmier, 2005). This is further support for the use of dance/movement therapy, which has a clear goal of sensory awareness as well as body and mind integration.

Movement Observations in Anorexia Nervosa

As mentioned above, one of the central concepts of dance/movement therapy is the reciprocal relationship between body movement/posture and cognitive, physiological,

and emotional states. Therefore, it may follow that individuals suffering from anorexia nervosa would exhibit similar movement patterns.

Researchers using Laban Movement Analysis have observed that women suffering from anorexia have a particular pattern of movement (Burn, 1987; Padrão & Coimbra, 2011). Laban Movement Analysis is a method of movement observation that objectively describes the efforts of body movements, the body's relation to space, and the shapes that bodies create to give a full descriptive picture of movement. Individuals suffering from anorexia nervosa show a specific and limited repertoire of movement that involves hyper-rigidity of the trunk, distal initiation of movements (using mainly hands and fingers), no elements of weight and grounding, and no engagement with the core (Burn, 1987; Padrão & Coimbra, 2011). There also seems to be a preference for bound flow over free-flow, where muscles are controlled in movement (Burn, 1987) or complete lack of flow with no sense of rhythm or time to music (Padrão & Coimbra, 2011). The element of weight is so focused on lightness that clients will sometimes walk on tip-toe and exhibit discomfort with movements or music that induce grounding (Padrão & Coimbra, 2011, p. 141). There are also patterns observed in their relation to space. Researchers have observed that clients with anorexia have little sense of their own personal space, choosing to make themselves very small by slouching, crossing their arms and legs and showing a discomfort with touch (Padrão & Coimbra, 2011).

The premise in dance/movement therapy is that these stereotypic movement patterns are indicative of the client's state of mind and that an expansion of movement repertoire will produce changes in thoughts and emotions.

Combining Drama and Dance/Movement Approaches

Integrating concepts and interventions from different creative arts therapy modalities can be one way to tailor the therapeutic process to the specific needs of a client population or to address a particular therapeutic issue. Using an approach she calls Psychodramatic Movement Therapy, Fran Levy combines psychodrama and dance/movement therapy with a variety of different clients who have difficulty expressing and organizing their emotions (Levy, 1979, 1988, 2014). She uses movement to activate physiological responses that initiate the cathartic release of thoughts, images, and emotions, which are then sorted through, organized and concretized within psychodramatic scenes (Levy, 1979).

Psychodramatic movement therapy takes thoughts and feelings released through movement and structures them into directed and focused dramatic action [...] thoughts and feelings are externalized and clarified in such a way as to add structure and content to previously inhibited and often confusing emotional material. (Levy, 1979, p. 32)

This type of emotional release could be an effective intervention in the treatment of anorexia nervosa, where a control of food serves as a method of hyper-vigilant control over the release of emotions. Providing a form of emotional release through the body would promote body awareness (Chaiklin et al., 2003; Daubenmier, 2005; Dosamantes, 1992; Krantz, 1999) while the containment of the scene provides the safe structure and emotional buffer necessary to lead to insight (Emunah, 1990; Landy, 1983).

Furthermore, the use of dramatic techniques allows for some verbal processing that clients with anorexia nervosa seem to gravitate towards (Jacobse, 1995). One of the

difficulties with the use of dance/movement therapy with adolescents suffering from eating disorders is that movement itself can be overwhelming and bring up feelings of self-consciousness and discomfort. Perhaps bringing movement into embodied roles could help to distract from a hyper-focus on the body itself and allow the client to modify movement in a more organic way:

Drama can act as an intermediary step connecting the intellect (words), with the body (movement). The inherent limitations of the artistic materials place a natural boundary around the psychomotor aspect of the experience, restricting the expression largely to finger, arm, shoulder and upper body movement on a defined space – the paper. These limitations can be helpful to some individuals for whom complete body action may initially be too threatening” (Levy, 1979, p. 197).

Bringing movement images into scenes is also a way to help make a connection between thoughts, feelings, and sensation, something that is needed for treating adolescents with eating disorders.

The role of movement in this combination is to bring up therapeutic content that is more directly related to the body than to intellectualization. When successful, this allows for new, unconscious material to surface. However, adolescents (especially those suffering from eating disorders) can sometimes have difficulty with movement sessions and benefit greatly from the structure of scenes where roles are more clearly differentiated and less threatening to their identities (Johnson & Eicher, 1990). While movement is used to access repressed and unconscious emotions, drama techniques work in two areas, “(a) internally by decreasing the ambiguity of emotional and feeling states,

and (b) externally by providing a safer container for the aggressive drives stimulated by the intimate environment” (Johnson & Eicher, 1990, p. 163).

Study Rationale

This paper describes my intervention with a group of adolescent girls who were either diagnosed with a restricting eating disorder or exhibiting restricting eating behaviours. I chose to combine drama therapy and dance/movement therapy interventions in order to target body image distortions and encourage social interaction within a structure that balanced emotional expression and containment (Emunah, 1990). Because this was a short-term group, interventions were focused on one aspect from each modality: scenework (from drama therapy) and the kinesphere (from dance/movement therapy). Below is an explanation of each term and a rationale for their use in the group.

Scenework

Scenework is the use of semi-structured, improvised scenes that can be either imaginative or realistic and involve interactions between actors. It was chosen as a way to provide structured exploration of thoughts and emotions as well as to target issues of problematic social interaction experienced by individuals with eating disorders.

Scenework is the second phase of Renee Emunah’s (1994) Five-Phase model for drama therapy. It follows the phase of dramatic play, where clients are warmed up through games that bring about the emergence of images and themes. The scenework phase is used to further externalize and provide structure to the themes that are uncovered in the first phase of a drama therapy session. The format of scenework can vary in terms of the amount of improvisation or planning that is involved, the use of props, and the amount of emotional distance that is involved in the scenes. Usually, scenes at this stage

play out situations and roles that are not part of the client's life in order to keep a certain amount of emotional distance.

The type of improvisation that was used in this group was *extemporaneous improvisation*. Here, there is not extensive planning or scripting of the scene, but clients can decide what parts they will play as well as other minor details such as setting, and the general situation that will be played out. This type of improvisation seemed fitting for the group because it allowed enough freedom for the client's internal state to be projected onto the scene while giving enough structure and direction so that clients would not feel overwhelmed by the task (Emunah, 1994). Some amount of structure and predictability is important with this population of clients who tend to focus on perfectionism (Bruch, 1978).

There are two main goals of scenework: to uncover the meaning of the role and to find new or alternative behaviours (Emunah, 1994). First, through playing out the role within a scene, the client may discover aspects of the self like feelings or behaviours that have meaning for them. If this discovery takes place, the therapist can help the client use the scene to practice new behaviours without the threat of severe consequences.

Kinesphere

The concept of the kinesphere is a category of space taken from Rudolf Laban's taxonomy of movement and method of movement analysis. Laban understood space as having four levels: 1) inner space, or the internal volume of the body, 2) personal space, or the kinesphere, 3) interpersonal space, or the distances between other people, 4) general space, or the general area where movement takes place, and 5) action space, or the area where the movement occurs (Fernandes, 2015, p. 199). The kinesphere is one's

personal space bubble; the space that can be reached by one's body without any shift of weight. Laban (1974) defines it as,

...the sphere around the body whose periphery can be reached by easily extended limbs without stepping away from that place which is the point of support when standing on one foot [...] we never, of course, leave our movement sphere but carry it with us, like an aura (as cited in Fernandes, 2015, p. 199).

The space around one's body can be defined in three categories: near-reach, mid-reach, and far-reach spaces. Near-reach space is the area that either touches one's body or is in very close proximity, usually inches away. Mid-reach space is slightly larger and can be described as the space that is approximately half an arm's distance away from the body. Far-reach space is the far extremity of the body's reach, or the periphery of the space bubble and beyond.

Defining and describing space in these terms shares similarities with the concept of body image proposed by Chaiklin and colleagues (2003) which includes the experience of one's body in interaction with its environment. Also related to body image and body awareness is the concept of psychological kinesphere; "a mover's sense of psychological space" (Fernandes, 2015, p. 200). This is the psychological awareness of the amount of space our body takes up in relation to objects and people around us.

Although the actual size of one's kinesphere remains constant, the size of one's psychological kinesphere changes in proportion to environmental pressures and the way that these pressures are perceived by the individual (Fernandes, 2015). For example, the psychological experience of one's kinesphere can shrink when a person is on a crowded bus because of the feeling that perhaps it *overlaps* the kinespheres of others. The amount

of actual space available to the person affects their perception of how much personal territory they can claim. Similarly, personality traits can affect the size of one's psychological kinesphere, where a shy person may perceive having a smaller claim to personal space than an outgoing one. Therefore, the psychological perception of one's body boundaries is a result of the interaction between external pressures, internal drives, and the awareness of one's body in space.

The concept of the kinesphere was the central focus of my movement interventions with this group as a way of targeting body image distortion and self-objectification. Kinesphere was also used in scenes where participants could become aware of their (personal and interpersonal) body boundaries when they interact with others and their environment. My hope was that the use of the kinesphere concept within scenework would help in developing a sense of body awareness in action.

Methodology

The goal of this exploratory case study paper is to describe the therapeutic group process of adolescent girls with restricting eating disorders when drama and dance/movement therapy techniques are combined. Practice-based inquiry requires a research methodology that is context-specific (Doktor, 1991; Hinz & Ragsdell, 1990; Padrão & Coimbra, 2011; Radmall, 1997; Silverman et al., 2013). Baxter and Jack (2008) outline Yin's (2003) criteria for considering case study research: "(a) the focus of the study is to answer 'how' and 'why' questions; (b) you cannot manipulate the behaviour of those involved in the study; (c) you want to cover contextual conditions because you believe they are relevant to the phenomenon under study; or (d) the boundaries are not clear between the phenomenon and context." (545). The sub-category

of exploratory case study is the preferred method when little information is known about the topic of interest and inferences are therefore difficult to make (Yin, 1994). This sub-type does not begin with the inferential *how* or *why* questions that suggest a preconceived hypothesis, but rather, it answers more open-ended *what* questions (Yin, 1994; Baxter & Jack, 2008) such as: What is the therapeutic process of adolescents recovering from eating disorders in a group therapy context combining techniques of drama therapy and dance/movement therapy? Research on the combined use of these techniques with this population is scarce, which is why I hope that an exploratory approach to case study may shed light on possible areas for further research. Exploratory case studies begin with limited information and assumptions cannot be made at the start, “the goal being to develop pertinent hypotheses and propositions for further inquiry.” (Yin, 1994, p. 5).

Steps to (Exploratory) Case Study Research

Yin (1994) lists five steps to conducting a case study: 1) designing the case study, 2) preparing for data collection, 3) collecting the evidence, 4) analyzing the data, and 5) writing and disseminating the report.

The first step of designing the study is based on the research question being asked. In this particular case, a *what* question that is context-specific is appropriate for an exploratory case study design (Baxter & Jack, 2008). The researcher must then decide what constitutes the case, which is defined by clear boundaries of place, time, and participants (Yin, 1994). Boundaries of the case can differ depending on the research question and the kind of case study being conducted. Because my research is exploratory, it requires more focus in terms of contextual boundaries and therefore involves narrow inclusion criteria for participants.

Step two involves deciding what kind of data will be collected. Case studies require thick description and triangulation, which means that several types of data should be collected (Baxter & Jack, 2008; Stake, 1978). Once data collection methods have been chosen, step three is to go out into the field, conduct the case study, and collect the evidence (Yin, 1994). Steps four and five, analyzing the data and reporting it, take place after the work with participants has been completed (Yin, 1994).

Data Analysis

Case study designs rely on a variety of evidence sources to create rich descriptions of the case that enhance understanding (Hinz & Ragsdell, 1990; Moneta & Rousseau, 2008; Padrão & Coimbra, 2011; Radmall, 1997; Silverman et al., 2013). Having a variety of sources is recommended as it allows for triangulation of the data and thematic analysis. Stake (1978) also argues for the legitimacy of tacit knowing and personal bias as a source of data within the case study because the method is so closely related to context. Deep understanding can be reached through the subjective experiences of participants and researchers, which strengthens the study.

Data for my study was gathered using participant-observation (Yin, 1994) as I led the group in drama therapy and dance/movement therapy exercises. Observations of participant behaviours, group member interactions, and verbalizations were recorded through note taking after sessions. Next, my observations were checked against the verbalizations from clients during the sharing portion of sessions where participants had an opportunity to speak about their experiences. The use of dance/movement therapy techniques required the recording of movement data through videotaping (Hinz & Ragsdell, 1990). Movement data was described using terms from Laban Movement

Analysis, with a focus on efforts and the client's relationship to space in terms of distances and interactions with the environment (Doktor, 1991; Hinz & Ragsdell, 1990; Padrão & Coimbra, 2011). Movement efforts are descriptors for the individual's overall movement quality within four categories: weight (light vs. strong), time (sustained vs. light), space (direct vs. indirect), and flow (bound vs. free).

Thematic analysis is an appropriate way to analyze the data that is collected in a case study (Braun & Clarke, 2006). There is no strict process for analyzing data using themes, however, the researcher should have a clear definition of what constitutes a theme. Things that could be considered thematic are number of instances, duration of instances, or overall "keyness" of an instance's relationship to the research question (Braun & Clarke, 2006, p. 82).

My approach to data analysis was to record themes based on number of instance, duration and how relevant they were to the topic of anorexia nervosa across all of the collection methods used: participant-observation, verbal sharing of the participants, and videotaping. Observations that were found across all three categories were given more weight for their inclusion as themes.

The Group

During my internship with the eating disorders team at the hospital, my supervisor suggested that I lead a short therapy group and asked that I propose ideas for the therapeutic frame and structure. Because the hospital receives many referrals for therapy, group situations offer an opportunity to maximize time, cost, and resources. A six-week, closed group structure was chosen due to time constraints and the upcoming ending of my internship.

Given the short amount of time, I proposed a narrow focus on the theme of interpersonal relationships and body image and titled the group “Relationship with the Self and Others Through Drama and Dance” along with a short paragraph summarizing the purpose of the group (Appendix D) and that it would involved some dancing and acting in scenes. My supervisor interviewed those who had been referred to the clinic for therapy and recruited participants. If they fit our inclusion criteria, she offered them the option of participating in the group or wait to receive individual therapy from one of the other therapists on site.

Inclusion Criteria

The criteria for inclusion were based on diagnosis type, safety, availability, age, and gender. Actively suicidal or self-harming patients were excluded, as were inpatients from the hospital. Those selected were well enough to be outpatients and not deemed by the medical staff to be in a severe crisis situation. Because it was a very short, closed group, clients were only offered the group option if they were available to attend all six sessions. In order to enhance group cohesion in this short time frame, we tried to select participants who had a similar lived experience in terms of diagnosis, age, and gender. We wanted to avoid anyone feeling that they could not relate to the experience of their peers. The final group included five participants between the ages of fifteen and seventeen who were suffering from restricting, rather than binge-purge eating disorders. All were diagnosed with either anorexia nervosa (AN) or eating disorder, not otherwise specified (EDNOS), with a restricting subtype.

The Plan

The concepts of kinesphere and scenework were interwoven into the therapeutic process to address body image distortions and interpersonal difficulties. A ritual was imposed on the process through the very structure of sessions. Sessions were divided into five parts: movement warm-up, scenes, movement closure, silent reflection, and verbal sharing. One of the main goals was to use the session structure and the movement themes to help manipulate emotional distance; meaning that early sessions included movement that focused on far-reach kinesphere exploration combined with fictional scenes that were emotionally over-distanced, whereas later sessions used near-reach kinesphere exploration combined with reality-based scenes that are more emotionally under-distanced. The basic 6-session plan is outlined in Appendix A.

Movement Warm-up. All sessions began with fifteen minutes of movement warm-up to music in a standing circle. Music was chosen for its strong consistent rhythm to encourage grounding and group synchrony. To open the group each week, participants were asked to offer a short movement or gesture that was mirrored by the rest of the group. These offerings made up the movement vocabulary used for the rest of the warm-up. Early sessions focused on synchrony, rhythm, and observation of distance between participants. Later sessions included transitions through space, changes in pathways, touch, individuality, and eventually, the encouragement of autonomy and creativity. Each week I imported another layer to the topic of the kinesphere to be explored in the warm-up. If themes emerged in this first part of the session, they were taken to scenes.

Scenes. Scenes were semi-structured with a format of extemporaneous improvisation. Whatever had been explored in the warm-up was taken to this part of the

session to be acted out. The concept of kinesphere was put into enacted, verbal action each week; first in imaginary scenes, and eventually in scenes about real life situations. Emotional distance was manipulated each session from far to near, just as the focus of kinespheric exploration was adjusted each week in the same way. That is, the first session involved scenes based on imaginary, non-human characters that allowed for a large amount of distance, while the final session used the enactment of real personal stories, thereby shortening the amount of emotional distance (Landy, 1983). Scenework was the longest portion of each session, usually lasting between thirty and forty minutes.

Movement Closure. I led an improvised slow movement closure after the scenes as a way of de-roling and encouraging the release of muscle tensions and relaxation through movement. Movement closure was also an attempt at reintegrating the body more fully after the process of intellectualizing through the scenes. My goal in leading this portion was to expand movement repertoire by making large movements to open the body and introducing touch to define body boundaries. Individuals suffering from eating disorders often have difficulty sensing and releasing muscle tension that is necessary for true relaxation, which is why relaxation through slow movement is also especially helpful for the identification of shifts in muscle tension (Totenbier, 1995).

Silent Reflection. Participants were asked to lay on their backs in silence and rest their bodies. This was included as a symbolic ritual of returning to oneself after a period of interaction with others. Each week, I read this exert to the group during this part of the session:

When I am in touch with myself, my feelings, my thoughts, with what I see and hear, I am growing towards becoming a more integrated self. I am more

congruent, I am more ‘whole,’ and I am able to make greater contact with the other person. (Satir, 1987 as cited in Chaiklin and Wengrower, 2009, p. 181)

Verbal Sharing. The final ten to fifteen minutes of sessions were devoted to verbal sharing of thoughts, feelings, stories, or experiences. This was a time to speak about whatever was on their mind at the time and there were no real ground rules.

The plan for the therapeutic process was to establish a clear structure from which clients could have the freedom to project thoughts, emotions and images. I imposed no focus on topics surrounding health or food, as “too much focus on physical well-being can reinforce the concept of the disorder as an illness in itself, where underlying factors are not relevant” (Dokter, 1995, p. 15). I also wanted to encourage a climate reinforcing the development of autonomy and trust in one’s abilities that is so important to a healthy sense of self (Dokter, 1995).

Participants

The group had five participants between the ages of fifteen and seventeen from diverse cultural backgrounds and all suffering from an eating disorder of the restricting type. All group members were from a middle or upper socio-economic status and lived in the city of Montreal. All were within normal weight range but were seeking therapy to address issues related to their eating disorders. All of the names in the participants’ names have been changed to respect confidentiality.

Erin

Erin was a fifteen-year-old girl of Caucasian background who was born in Vancouver but had spent most of her life since childhood in Montreal. When she was first admitted to the hospital one year prior to this therapy group, Erin weighed only 37.6 kg

for her 168 cm height. She complained of a fear of weight gain and experienced symptoms of fatigue and intolerance to cold. She was admitted to the day program at the hospital where she was subsequently diagnosed with anorexia nervosa, restricting type. Following her discharge, Erin began family therapy, was prescribed Prozac, began to take yoga classes at the hospital and gained weight consistently. Doctors reported that she was doing well but just before her participation in the group, Erin began to report feelings of sadness and an urge to self-harm.

Her initial presentation in session was shy and unassuming. She was quiet, speaking only minimally but had a sweet smile and could maintain good eye contact with myself and the other group members. Her posture was slouched with arms crossed and legs crossed at the ankles. She had a habit of fidgeting with her clothing and hair, often adjusting her shirt or skirt around the abdomen.

Sarah

Sarah was a sixteen-year-old girl of Turkish descent who had spent most of her life in Turkey and had been living in Montreal for one year. Her first visit to the hospital's clinic was six months prior to group therapy, at which point Sarah was underweight for her height, not menstruating, and complaining of daily headaches. Her medical files indicated that she had been diagnosed with anorexia nervosa, restricting type three to four months prior and had been restricting her food intake for the past year. Her older brother was bringing her to medical appointments while her father was still living in Turkey and preparing for a permanent move to Montreal. Sarah's weight gain was slow, but she eventually reached a healthy weight. Along with group therapy, she received family therapy at the hospital. She reported consistent fear of weight gain and

an urge to restrict food during periods of stress. She indicated her triggers were the sensations of digestive issues like bloating, diarrhea and constipation, but she expressed feeling motivated to be healthy.

In the group, Sarah often smiled and giggled. She did not maintain eye contact for very long and often shifted her weight from side to side while standing. She spoke quietly and sparsely, but the content of her verbalizations was habitually related to her feelings of insecurity, shyness or inferiority and asking the group or the therapist for advice.

Chloe

Chloe was seventeen years old and the oldest member of the group. She was of Chinese descent and was born in China but had been living in Montreal since early childhood. I was unable to get full access to Chloe's medical chart and therefore have limited information on the specifics and progress of her eating disorder. The part of the chart that I was able to access noted specifically that Chloe should not be called at home. Sometimes, this specification is made when family members are unaware that the patient is coming to regular appointments at the clinic. Chloe also briefly mentioned in a session having a difficult relationship with her father, and having met him for the first time at the age of six. Along with group therapy, she also attended weekly sessions in individual art therapy at the clinic.

In the group, Chloe was by far the quietest member. Although she was the tallest, she slouched, kept her gaze towards the ground, and covered her face with her hair, making her seem invisible. When she did speak, her voice was almost inaudible and she showed no facial affect. Week after week, the opening gestures that Chloe brought to the

circle seemed to me to represent sad or violent imagery, such as curling up into a ball or making a stabbing motion towards her chest. Chloe seemed to be most fearful of social interaction with the other group members but was observed making a few attempts at saying hello and asking questions to make friendly conversation after sessions.

Beth

Beth was sixteen years old and diagnosed with anorexia nervosa, restricting type with episodes of purging. Both of her parents were from Iran but she was born and raised in Montreal. At the start of group therapy, Beth had attained a healthy weight but reported to doctors an extreme fear of weight gain while only having gained one kilogram in the past year. She was eating well, had not reported any new episodes of purging and was seeing a psychotherapist weekly.

In the group, Beth's physical presentation sometimes seemed to be at odds with her behaviours. For example, her affect was often hard or frowning and her body posture was closed with arms crossed but she regularly took on the role of helper by volunteering to go first in activities and offering advice or words of encouragement to other group members. Beth was one of the most talkative participants, speaking at an appropriate volume and making eye contact and initiating topics of conversation. She was also the group member who clarified her personal boundaries and limits the most by expressing what she felt uncomfortable with during certain exercises.

Eve

Eve was a fifteen-year-old girl of Egyptian background diagnosed with eating disorder, not otherwise specified. The medical chart indicated that Eve was at normal weight but was referred to medical, nutrition, and therapy appointments due to regular

episodes of food restriction and a desire to lose weight. She reported skipping meals and exercising but explained that other family members used this method of dieting for weight loss. Doctors at the clinic were concerned that Eve or her family did not fully understand the dangers of eating disorders or the importance of proper nutrition.

In the group, Eve stood out as the only girl wearing a hijab and also as the most talkative and outgoing. She would speak freely, smile, make eye contact and quickly took on a leadership role during sessions. She volunteered to be first to perform in scenes and showed a larger movement repertoire than her peers during warm-ups. Eve also seemed more comfortable dancing than the other participants, moving rhythmically in both upper and lower portions of her body, as well as being able to initiate movement from the trunk. Unfortunately, Eve only attended the first two sessions of therapy.

Therapeutic Goals

Participant Goals

As a means of introducing the topic of personal goals in the first session, I asked the participants to write down any worries that they may have about the group. Every single group member wrote that they worried about being judged, disliked or not getting along with the other participants. Most of them also wrote about feeling out of place and being physically inferior to others. Two participants also identified that they worried the group would take time away from schoolwork and negatively affect their grades. This could be an example of the perfectionism that is observed in patients with anorexia nervosa (Bruch, 1978).

Next, they were asked to write down their goals. All of the five participants identified a goal having to do with improving their social interactions. They wrote about

a desire to be less shy, be more social, and opening up to others. All of them also identified a goal of dealing with their emotions better. Specifically, they wanted to be able to let go and manage feelings of anxiety. Interestingly, although all participants wrote that they worried about their physical appearance the feeling of inferiority it brought forth, only one group member identified a goal having to do with body image. Personal goals were overwhelmingly focused on developing better relationships with others

Therapist's Goals

My goals for the group were to encourage a fully integrated sense of body image, to help externalize emotions, and to improve social interactions. In terms of body image, dance and movement exercises were used to expand movement repertoire and create an integrated, felt sense of the body. Dance was also used as a means of helping emotions surface through physiological sensations. Drama was used as a structured externalizing tool where clients could project their emotions onto characters within structured scenes. Scenes also served to explore different types of social interactions and to make connections between body and affect.

Therapeutic Process

Beginning Phase

The beginning phase was an introductory stage to allow the participants to become comfortable interacting with each other in movement and scenes. The first session involved only games and no scenes. The second session began with play that turned into group improvisation and to the creation of structured scenes. Proximity in movement was restricted to far-reach space (the periphery of one's kinesphere or space

bubble) and scenes were fantasy-based to provide plenty of emotional distance.

Participants were very quiet in the beginning and indicated a preference for minimal movement and a discomfort with close proximity.

Resistance to Body Movement. Participants had flat affect and moved as little as possible. When they were asked to move in gesture circle, for example, they did so only with their arms and without involvement of the torso or the lower limbs. Movements were slow, minimal and disconnected from musical rhythm. Body postures were closed; participants slouched, crossed their arms, and crossed their legs. The desire to move as little as possible was even verbalized in Session 2 by Erin when choosing which sea creature role she wanted to play saying, “I want to be a starfish so I can lay on the ground.” These observations support those of previous research on the movement patterns of clients with anorexia nervosa (Burn, 1987; Padrão & Coimbra, 2011). Here, the restriction of movement can be seen as an attempt to reduce physiological sensations and the expression of emotions (Berger, 1972; Bruch, 1978; Chaiklin et al., 1992; Vanderlinden et al., 1993; Payne, 1995).

Internal Focus and Resistance to Physical Proximity. Eye contact within the group was almost non-existent. Participants’ focus was seemingly so internal that there was hardly any relationship to the element of space: there was minimal acknowledgement of others, and a clear preference for standing along the periphery of the room or against the walls. Participants stood at far (more than arm’s length) proximity from one another and were avoidant to touch. In Session 1, group members were able to bring personal awareness to this preference and indicate it to others through gestures. This internal focus also caused asynchrony in terms of group movement exercises. Participants did not

move synchronously to each other or to the rhythm of the music. In scenes, actors used props to physically interact with each other, for example, by throwing something to another person rather than handing it to them in close proximity. In the sharing portions of this stage, discussions centered on the difficulty in opening up to others or taking the first step in speaking to new people. A common feeling of insecurity was expressed by Eve in Session 2, to which everyone else nodded: “I don’t know about you guys but I always have a fear of being judged” (Eve, personal communication, Session 2). The fear of being judged was central and permeated throughout the entire therapeutic process.

Passivity and Helplessness. The theme of passivity was present both in scenes and in the movement behaviour of the participants. In movement, participants moved in either extreme lightness or in passive weight. Passive weight is the absence of weight, meaning that it is either light nor strong. This passive weight was evidenced in the standing postures of the clients, who slouched and gave into gravity with minimal force required to keep them upright. In movement, lightness was most prominent. In this case, there was a resistance to gravity, for example, walking on tip-toe and placing each foot lightly on the ground rather than stomping. This theme supports previous observations of the movement repertoire of clients with anorexia nervosa (Burn, 1987; Padrão & Coimbra, 2011). This avoidance of grounding can be seen a way to avoid feeling one’s body and repress the associated emotional states (Vanderlinden et al., 1993).

In fictional scenes, passivity was combined with helplessness. Three out of the four participants in Session 2 took on the roles of passive or defenseless creatures with minimal movement (turtle, starfish, and coral), while two group members chose active creatures (dolphin and seahorse). The passive characters behaved, not only passively

within the scenes, but were also quite helpless to threats from other characters. For example, Chloe, who chose the role of turtle, did nothing to escape or fend off the threatening character of the seahorse that was trying to eat her. Chloe retreated into her shell while the starfish bit at her and simply froze in place, waiting for the dolphin character to come and save her. If taken as a metaphor for the client's personal coping mechanisms, anorexia nervosa is an internalized way of dealing with external threats. The individual with anorexia nervosa would prefer to be agreeable, avoid confrontation and control herself rather than act out onto the environment (Bruch, 1978), as demonstrated in Chloe's character's reaction in the scene.

Food and Threat. Several references to eating were made in the early stage of the group process. All of these references were within fictional scenes and related to threatening social interactions. In the second session, participants were asked to create structured scenes in small groups to present to each other. Although the groups had no contact with each other during the preparation, both of their scenes featured the conflict of one sea creature attempting to eat another creature. In both cases, the threatened creature was passive and defenseless. After the scenes, Eve offered this explanation for why her seahorse character was trying to eat the turtle:

You see, there's a reason why things happen. You see, the seahorse was being bugged and she was like, having a bad day, she didn't deserve that. And she is throwing a fit... she's like, picking on someone else because, you know, she doesn't want to hurt people she knows (Eve, personal communication, Session 2). Here, Eve explains her character's actions but also seems to comment on problematic social interactions in general. She acknowledges that her character is hurting another but

reasons that the assailant's personal pain is the initiating factor and that the behaviour is an attempt at saving loved ones from pain. It is also important to note that the threat of choice is eating; something that Eve and her fellow group members restrict and repress in their own lives.

Middle Phase

The therapeutic goal of this phase was to expand the participants' repertoire of movement and bring awareness to the body in space through the introduction of the concept of the kinesphere. Far-reach space was contrasted with mid and near-reach space to encourage closeness and intimacy between the participants. In scenes, participants were asked to play characters with specific kinespheric preferences (far, mid, or near). I imported movement exercises that encouraged variations in physical proximity as well as changes in movement pathways through the space. As of the third session, Eve stopped attending the group, which changed the dynamic. The departure of a group member seems to have triggered a desire for closeness and intimacy in the other participants. Scenes were transitioned slowly towards realistic situations rather than fantasy, thereby reducing the amount of emotional distance. The salient themes of the group reflected this change in dynamic.

Personal space. Near-reach space was introduced in the third session. There were initial reactions of giggling but also awareness that variations in physical proximity could trigger feeling states of comfort, nervousness, or loneliness. Often, these feelings were verbalized within the scenes. Most common at this stage, seemed to be the newly acquired ability to experiment with variations in physical proximity, while also being able to assert personal preferences. This demonstrates an awareness of one's own body

in space in relation to the bodies of others, as well as a conscious awareness of the feelings that this stirs up. For example, in Session 4, Erin and Sarah played out a fictional scene as acquaintances who meet at dance party. Each actor was assigned a different kinesphere preference at random by me; Erin's was near-reach while Sarah's was mid-reach. The participants decided before the scene that the characters had a romantic interest for each other. As the scene played out, both characters made attempts with their bodies to demonstrate their physical preference; Erin moved closer as she danced, while Sarah turned her body to the side while continuing to engage in conversation. After the scene both girls made emotional associations to what had taken place. Erin commented that Sarah's body language was sending her "mixed signals" and made her feel "a bit rejected" (Erin, personal communication, Session 4), while Sarah interpreted her own character's behaviour as shyness.

Also important to note was the strong desire for closeness that developed in Session 4, which was of marked difference from the clear preference for far-reach space in the beginning phase. This change was obvious as of the warm-up, in a game of Gather/Scatter. I introduced this game, with the goal of bringing awareness to personal choices in physical proximity. Participants were scattered about the room and were invited to yell out "gather" if they wanted to bring the group back together or "scatter" if they preferred to return to their own individual spaces. I yelled out "gather" first to demonstrate this and the group came together in a tight circle, inches away from each other, where they stood in complete silence for over four minutes. Participants were able to verbalize that this specific distance felt "safe" and clarify their enjoyment for this specific distance; not farther apart and not closer together. I personally felt a strong sense

of intimacy permeate through the group at this point and a noticeable change in dynamic. The intimacy created at the beginning of the session continued throughout and was also reflected in the final discussion, where participants shared intimate feelings of insecurity and a desire for social connections.

Relationship to the General Space. Changes to the participants' relationships to space were observed at this stage. In the movement warm-up, I introduced variations in formations other than the circle and ways of moving through the room. These variations also seemed to be reflected in the behaviours of the clients. In a Session 3 scene, Sarah and Chloe took on the roles of bacteria that they described as "floating around" in space. Although effort qualities were largely unchanged (ie. a clear preference for lightness and avoidance of grounding), spatial references expanded and were less rigid as the clients meandered through the room. This is perhaps an example of personal choice that was influenced by the introduction of new movement repertoire in the warm-up.

Conflicts and Conflict Resolution. Participants began to explore both personal and interpersonal conflicts in fictional scenes at this stage. The most salient example of this is in the scene mentioned above from Session 3 where Sarah and Chloe interact as bacteria floating in space. Chloe took the role of the mother bacterium who preferred far-reach space and Sarah the role of the baby bacterium who preferred near-reach space. This instantly created a dynamic that was uncomfortable for both actors, and was verbalized by the baby bacterium, who said to its mother, "You're making me nervous. Do you want to come closer?" In response to this, the dynamic of mother and baby was more deeply explored, making possible reference to the relational issues surrounding the actors' eating disorders. In an attempt to make contact while remaining in far proximity,

the mother bacterium offers the baby some cake and the baby vehemently refuses to eat it. After this rejection, the mother suddenly announces that she is dying and asks the baby if she will be attending her funeral. The baby seems so focused on the physical distance between them that she largely ignores this request and painfully asks, “Why would you stay over there? You’re my mother,” to which the mother responds from the other end of the room, “I still love you.” At this point in the process the content seems largely unconscious to the clients, yet deep issues come to the surface through projection onto the characters. During the sharing portion of this session, a discussion on the desire for social connections ensued, with participants expressing their difficulty with making friends. They discussed the idea of boundaries, individual preferences and insecurities that make social interactions complex and challenging.

The manipulation of distance in this phase seems to have triggered deep, unconscious emotional material related to interpersonal issues with family and loved ones that are theorized to be of crucial importance in the development of anorexia nervosa (Bruch, 1978; Bulik et al., 2007). Scenes were fictional and fantasy-based, which provided clients with emotional distance from the material. This is an example of aesthetic distance, where the ideal amount of distance resulted in the externalization of unconscious emotions (Emanah, 1990; Landy, 1983). At this stage, externalization was unconscious and not yet leading to insight.

There was also a transition towards finding solutions and resolving conflicts. Whereas in Session 3, all scenes involved some type of interpersonal conflict between the characters, all of them ended in a state of ambiguity and were unresolved. However, in Session 4, participants jumped to quickly resolve any conflict that arose in a scene,

usually by compromising their character's own personal wishes; for example, by both insisting on giving up an object that they both parties wanted.

End Phase

In the final phase, I reduced the amount of emotional distance in the sessions while still preparing the clients for the termination of the group. Near-reach space was encouraged and enhanced in the warm-ups using the effort of strength through presses and pulls between group members. Scenes were about real interactions in the clients' own lives to make them under-distanced and to attempt to connect movement with emotions and affect. Also, movement focused on the extremes between closeness to and separation from others. Only two clients attended the final session. Perhaps the movement towards more under-distancing combined with the nearing of termination was too unsettling and contributed to clients leaving the group early. Under-distancing may have created a situation where clients questioned whether it was safe enough for them to feel and share emotions, knowing that they would soon lose the support of the group. Below are the important themes and changes that were observed at this stage.

Changes in Movement Behaviours. Although the main effort of lightness persisted until the end of the therapeutic process, slight changes were observed in terms of the clients' movement choices. For example, in the opening gesture circle, participants began to experiment with changes in levels, from standing tall to crouching and leaning. Use of the kinesphere was more complete, with participants making bigger movements and using up more space. They began to make self-aware comments such as "I don't want to take up all the space" (Beth, personal communication, Session 5) when asked to share stories. These seemed unconsciously related to the new way they were using their

bodies and the ensuing emotional impact. Physical proximity was also reduced, with clients standing closer together in the circle and becoming comfortable with touch.

There seemed to be a greater awareness of the body by the end phase of therapy, with clients verbalizing how things felt. For example, in the final session, in an attempt to enhance the feeling of strength and balance, Chloe and I each linked arms on either side of Sarah and slowly leaned outwards. Sarah's reaction was to immediately giggle and exclaim, "I'm splitting!" (Sarah, personal communication, Session 6).

Interactions and Objectification. All of the real-life scenes of the end phase were of interactions displaying personal experiences with objectification and self-objectification. The clients described moments of feeling judged by others and judging themselves for their physical appearance as a measure of their worth when making connections with others. All of the interactions that were enacted were about an attempt at speaking to a male love interest. Insecurities regarding male judgements of their physical appearance were a common thread among the group. This theme gives support for the premise that the male gaze (more so than any other gaze) is a particularly salient contributing factor to the internalization of objectifying ideas for young women (Calogero, 2004). One prominent example is in Session 5 when Sarah described a social interaction with a boy that she likes. She explained that she felt worried and pressured about this boy possibly wanting to explore sexual acts with her: "I learned that he wants more than just holding hands but I can't give that to him" (Sarah, personal communication, Session 5). Sarah went on to describe her insecurities about her appearance his assumed preferences and her wish to be desirable while comparing her own looks to those of her peers:

He's a fitness freak, so he wanted a girl with like, those big boobs, big butt, and I'm not that kind of girl [...] I actually feel a little disappointed because there's a girl in our school, he dated her and people say [pause]. I don't know, I don't like the way I look but people say, "she's [the other girl] not perfect, I don't understand why he wouldn't like you." But it's not like that. I felt like I'm not as good as her. (Sarah, personal communication, Session 5).

This example of insecurities and self-objectification reflects some of the other feelings expressed by the rest of the group. After Sarah explained the interaction with this boy and talked about her feelings, she was able to pick some of the other group members to enact the situation for her. Beth, taking on the role of Sarah, was able to easily improvise an internal monologue about not being good enough that concretized Sarah's feelings about the situation and allowed Beth to externalize her own feelings of insecurity.

Everyone benefitted from some sort of externalization, whether they were speaking, acting, or witnessing the scene. The chosen scene was voted by the group and had a main universal theme for everyone. Clients were able to witness the externalization of an internal monologue that they related to within the safety of distance provided by the scene. However, the material in these scenes was more superficial and conscious because the enacted situation was real. The ensuing emotions were therefore more superficial and conscious, whereas the use of fantasy in the middle phase seems to have brought out deep, unconscious emotions regarding interpersonal conflicts with loved ones.

Intimacy vs. Separation. The dichotomy between close intimacy and individualistic separation was enhanced during the stage. This could be a reflection of the interplay between extremes in physical proximity that I brought into the movement

warm-ups. Participants were led to oscillate between moving synchronously in a tight, connected circle and transitioning to individual, meandering movements in the room where they were encouraged to move creatively as they wished. Transitions between these two states seemed to be uncomfortable for the group. This could be because the movement warm-ups served as an unsettling metaphor for the upcoming ending of the group, and only two participants attended the final session. There was a change in terms of how the participants responded to intimacy and synchrony. Whereas in the first stage, they showed discomfort with close proximity and had difficulty moving synchronously, they began to seek these out as the ritual of the group session was established. Moving independently was possible but only for a very short time, before the participants returned to the safety of the circle.

Similarly, their behaviours in regards to separation and individuality changed. Whereas in the beginning, clients separated to retreat internally and without any connection to the space, now they were able to separate consciously for short periods to explore the space around them and express themselves creatively. The difficulty that the group demonstrated in transitioning between intimacy and separation may be an example of the boundary confusion that takes place in adolescents who have a lack of clarity in their personal identities (McIntosh et al., 2000). Intimacy and closeness leads to a loss of identity (external boundary confusion), while separateness highlights the feelings of impaired and incomplete personal identity (internal boundary confusion) (McIntosh et al., 2000). The fact that the group members began to feel comfortable with closeness and were able to express individuality could be a sign that body image and identity was developing more clearly.

Termination

Only two clients attended the final session of the group. Eve stopped attending after the second session, saying that she was busy with other things, Erin had a planned family vacation on the final week, and Beth, who had attended all previous sessions did not contact me before the final session to say she would not be there. I was unable to reach Beth after termination to find out why she had not attended. Although Beth did not give a reason, I hypothesize that perhaps the level of under-distancing during sessions near the end of the process may have been too overwhelming. Saying goodbye is always difficult, but separation can be especially difficult once intimacy and vulnerability have surfaced. Although Beth was quite retreated in the first session, she had begun to share feelings of insecurity and sadness by Session 5. Perhaps knowing that the group was coming to an end during this vulnerable time and that she would not have sufficient time to address newly emerging issues was overwhelming for her. Knowing that this population seems to have difficulty expressing negative emotion and being vulnerable with others, it might have been a safer choice to maintain the medium amount of emotional distance that was attained in the middle phase, rather than continue to enhance under-distancing until the end.

Chloe and Sarah were the only two participants in attendance, which changed the group dynamic greatly. There was much more interaction with me than with each other, however, they seemed much more open to close proximity, touch, and experimenting with movements perhaps because there was no one but me to watch their interactions. I was able to easily lead them in partnered exercises, such as rolling across the floor while holding hands, or pulling on each other and balancing as counter-weights. During these

movement exercises, Sarah and Chloe were able to connect physical sensations with emotion, such as verbalizing that pushing against the wall made them feel strong, whereas balancing made them feel anxious. Chloe, who had been the most quiet and effaced member of the group was able to make sustained eye contact and speak at louder volume during this session. No post-group interviews were performed, which makes it difficult to discern whether or not the participants had noticed changes in themselves. In the sharing portion of the termination session Chloe shared that attending the group helped her feel more comfortable to approach and speak to people in her life.

Discussion

The goal of this case study was to describe the therapeutic process of a group of adolescent girls with anorexia nervosa within a new therapeutic context. Combining the concepts of scenework and kinesphere was chosen to address what I judged to be prominent issues faced by adolescents with anorexia nervosa. This assumption was derived from what I observed in individual sessions with this population at the hospital and from the corroborating theories, mainly, self-objectification, body-image distortion, and internalization of emotions. The observations made during the process supported much of the research on anorexia sufferers, primarily the participants' reticence to express emotions (Bruch, 1978; Geller et al., 2000), their restricted movement patterns (Burn, 1987; Padrão & Coimbra, 2011), and their tendency towards internalization of the objectifying male gaze (Calogero et al., 2005; Calogero, 2004; Fredrickson & Roberst, 1997). Changes in their movement behaviours were observed by the end of the process and scenes allowed them to externalize certain emotional issues. The particular

combination of dance/movement and drama therapy concepts appears to have had specific impacts on these changes.

The Impact of Dance and Movement

Dance and movement were used in the warm-ups to increase the awareness of body sensations that would allow clients to respond appropriately to their bodily needs and create a more integrated body image. Beyond its use as a sensory-building experience to promote body awareness, movement also functioned as a powerful metaphor for exploring issues of interpersonal relationships when it was focused on the concept of the kinesphere. In simple terms, near-reach space was an easy metaphor for closeness and intimacy, while far-reach space could be associated with independence or separation. This is because being at a specific distance from another person produced associated emotions. Combining different kinespheric distances and calling attention to one's associated feelings can inform the client about what she feels in different situations and contexts. It encouraged the clients to ask themselves what it feels like to be near or far from another person and eventually, ask why it feels that way so that she could attend to the emotion rather than repress or control it. Does being close to this person make one feel secure or crowded? Does being far from that person make one feel independent or lonely?

Movement helped warm up the client's bodies to the work and also warmed up the material towards specific themes of boundaries, personal preferences, isolation, loneliness, crowdedness, family dynamics, etc. Movement allowed these themes to surface unconsciously and be explored on a body level first. It seems clear from the sessions that the kinesphere distances explored in the movement warm-ups were related

to the themes explored within the scenes. The introduction of near-reach space led to much more intimate scenes where feelings of vulnerability surfaced. For example, the bacteria scene from session three saw Chloe and Sarah play out feelings of love and rejection as related to insecurities and personal boundaries. Similarly, introducing changes in movement pathways in the warm-up allowed the participants to bring these new relationships to the space within real-life contexts in the scenes where they were associated with real emotions.

The Impact of Scenes

As the movement warm-ups helped define the themes of the sessions, the themes themselves were concretized and more deeply explored in the scenes. The scenes offered structure and more conscious action to the metaphorical material that emerged during the warm-ups. Just as the amount of physical distance was manipulated in the warm-ups, the amount of emotional distance was also manipulated during the scenes from over-distance to under-distance. Early scenes were fantasy-based while later scenes were real-life events that had the potential of being more emotionally vulnerable. The amount of distance had a clear impact on the type of scenes that the clients chose to create and the kind of emotional material that emerged. The fantasy-based, over-distanced scenes brought out more unconscious and emotionally vulnerable material that seemed largely unnoticed by the participants. For example, the scene in Session 2 where Eve as a sea creature attempts to eat another character featured emotions of aggression, threat, and difficult relationships with food that did not resurface in more under-distanced scenes. This scene also allowed Eve to verbalize insightfully about the desire to protect loved ones from aggressive impulses, pain and anger. Similarly, a scene where clients were in

the non-human roles of bacteria generated a deep theme of conflictual mother-daughter relationships that was unconscious and was left unexplored in later sessions. On the other hand, the real-life, under-distanced scenes generated more conscious and superficial emotions about the dynamics between boys and girls and self-objectification. Although the expression of feelings of body insecurity was important and highly related to their disorder, it was also a topic that is often a natural part of adolescence and not as emotionally vulnerable as the scenes about impaired family dynamics. Perhaps clients consciously chose to explore more superficial material because the realness of the scenes would generate overwhelming vulnerability. It is also possible that since the under-distanced scenes were suggested near the end of the process, clients may have rightfully feared that very vulnerable material would be left unresolved by the time of termination.

Although it was difficult for clients to stay in character, fully embody characters, and be exposed in front of their peers, everyone in the group participated in the scenes. Even through the discomfort, scenes generated laughter, encouragement, and discussions that were deepened during the sharing portion of the sessions.

Implications for Future Inquiry

It is my hope that this paper can be a preliminary step in further research on the combination of the kinesphere and scenework concepts for the treatment of adolescents with anorexia nervosa. I believed that the progression from non-verbal movement to structured scenes, allowed for the integration and the verbalization of emotions at the end of the sessions that, if continued, could impact the client's behaviour outside of the clinical setting. Observations during the process indicate that the warm-ups, which were based on the use of the kinesphere had an impact on the themes of the scenes. The

resulting scenes featured the main issues that were targeted for treatment (ie. impaired social functioning, distorted body image and self-objectification and internalization of emotions).

In hindsight, I would have made some changes to the process. Mainly, I would have kept the scenes fantasy-based for the entire therapeutic process, or until there was a clear indication from the clients that they were ready to move onto more vulnerable real-life scenes. Knowing that one of the main issues faced by this population is internalization of emotion and avoidance of emotional vulnerability, I believe that future treatment groups using these methods should be mindful of how under-distanced scenes may lead clients to express more superficial emotions. On the other hand, fantasy-based scenes will generate much deeper emotions due to their being unconscious to the client. More deep emotions could have surfaced if fantasy-based scenes had been continued throughout the entire process. Even though it was unconscious, a longer therapeutic process using fantasy-based scenes could have led to a natural process of personal insight eventually over time.

The main limitation of this structure was the short duration of the therapeutic process. Six weeks is a very short time to explore and resolve the deep issues involved in anorexia nervosa. It seems that the six-session time frame was enough to begin making the clients comfortable with each other and with becoming vulnerable. Participants quickly projected emotional material onto the fictional characters in the scenes but simply did not have enough time to fully explore and resolve these emotions. I propose that future use of this combination of techniques should be over a long-term treatment process.

Another limitation was the small size of the sample. Although some level of observation and understanding was reached about this particular group of clients, the results cannot be generalized to other groups. On the other hand, the group was surprisingly diverse in terms of cultural background (Chinese, Turkish, Iranian, Egyptian, and European), which may give support for the intervention's appropriateness for different types of cultural groups. It may be difficult to reproduce this process with a larger group because of the self-consciousness and insecurity that participants with anorexia nervosa feel when interacting with others. The small sample size allowed for a certain level of intimacy that helped the clients feel comfortable participating in the exercises. More research should be done with other groups to deepen our understanding of the possibilities of this type of intervention with adolescents diagnosed with anorexia nervosa.

Being a qualitative inquiry, no measurements were made and therefore none of the observations can be generalized. It would be interesting to include quantitative measures with this type of group in the future in order to understand what kind of improvements, if any, can be made using this intervention.

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Appendix A

Summary of Sessions Plan

	Movement Warm-up	Scene/ Main Exercise	Movement Closure
Session 1	<ul style="list-style-type: none"> - Gesture circle based on greetings. (ex: offer a greeting gesture to the group) - Movement restricted to one area of the room, in circle formation 	<ul style="list-style-type: none"> - Group forms 2 lines facing each other. One line walks towards the other displaying an energy/emotion (ex. Quickness, anger, cheerfulness, etc.) - Those who are not moving gesture their partner to stop advancing at their preferred distance -Mirroring exercise in partners 	<ul style="list-style-type: none"> - Fully led by therapist - Sustained movements connected to breath
Session 2	<ul style="list-style-type: none"> - Circle formation - Exploration of one's own kinesphere (far-reach) 	<ul style="list-style-type: none"> - Fictional scene involving the whole group and therapist (Under the Sea) - Choice of fictional character and creation of short scenes to present in small groups 	<ul style="list-style-type: none"> - Partly led by therapist making suggestions for moving in one's own personal space
Session 3	<ul style="list-style-type: none"> - Gesture circle - Introducing touch (near-reach) through hand holding - Variations in formations: lines and circles - Movement through space as a connected group: big/small circle, interweaving lines - Game of "Tag" 	<ul style="list-style-type: none"> - Fictional scenes in partners - Physical distance preference of each character picked from a hat - Details of the scene chosen by audience members 	<ul style="list-style-type: none"> - Sustained movements connected to breath - Variations in levels (moving on the floor) - Variations in distance from others
Session 4	<ul style="list-style-type: none"> - Gesture circle. Movements repeated in far, mid, near-reach distance from others - Game of "Gather / Scatter" 	<ul style="list-style-type: none"> - Fictional scenes in partners - Physical distance preference of each character picked from a hat - Audience decides what 	<ul style="list-style-type: none"> - Focus on moving in close proximity to others

		<p>kind of relationship is represented and details of the scene</p> <ul style="list-style-type: none"> - Audience sculpts the characters into starting positions 	
Session 5	<ul style="list-style-type: none"> - Gesture circle with sounds - Movements repeated in far, mid, near-reach distance from others - Use of movement vocabulary from gesture circle to explore individually in the space 	<ul style="list-style-type: none"> - Enactment of real-life personal stories, “an interaction that you are thinking about” - Personal story enacted by group members, not storyteller 	<ul style="list-style-type: none"> - Focus on variations in physical proximity
Session 6	<ul style="list-style-type: none"> - Gesture circle. Movements repeated in far, mid, near-reach distance from others - Break of circle formation - Transitions between synchronous movements and individual choice 	<ul style="list-style-type: none"> - Enactment of real-life personal stories - Two-part scenes: current issue and future projection 	<ul style="list-style-type: none"> - Focus on clear transitions in physical proximity (ex. from touch to far across the room)

Appendix B



CONSENT FOR CLINICAL PAPER

Participant: _____

Drama Therapy Student: Cindy Vielleuse (514-412-4400, ext. 23662)
Concordia University
1455 de Maisonneuve Blvd. W.
Montreal, QC
H3G 1M8

Practicum Supervisors: Sally Cooke, M.A., Art therapist, on-site supervisor
Susan Ward, R-DT, academic supervisor

Research Advisor: Yehudit Silverman, R-DT, R-DMT

Background Information:

One of the ways creative arts therapy students learn how to be drama therapists is to write a research paper that includes case material from drama therapy sessions. The purpose of doing this is to help them, as well as other students and creative arts therapists who read the thesis, to increase their knowledge and skill in giving drama therapy services to a variety of persons with different kinds of problems. The long-term goal is to better help individuals who enter into therapy with drama therapists in the future.

Permission:

As a student in the Master's in Creative Arts Therapies Program at Concordia University, I am asking you, for permission to write on the clinical process of the six-week therapy group you are taking part in from January 27th, 2015 to March 3rd, 2015. This permission includes description of group activities as well as direct quotes from the sessions, always while maintaining your complete anonymity.

Confidentiality:

The resulting clinical review will be posted in the academic database of Concordia University, which is accessed by other academics and students for educational purposes. Because this information is of a personal nature, it is understood that your confidentiality will be respected in every way possible. Neither your name, the name of the setting where your drama therapy took place, nor any other identifying information will appear in the research paper.

Advantages and Disadvantages:

To my knowledge, this permission will not cause you any personal inconvenience or advantages. Your treatment will not be affected based on this consent. You have the right to withdraw your consent at any time before the thesis is completed with no consequences and without giving any explanation. To do this, or if you have any questions, you may contact my supervisor (Sally Cooke, 514-412-4400, ext. 23903).

Signature of Participant or Guarantor

Date

Witness to Signature

Date

Appendix C



CONSENT FORM FOR PHOTO AND VIDEOTAPING

Authorization for photography, moving pictures, tape-recordings, etc. related to Creative Arts Therapies.

I, the undersigned

authorize CINDY VIELLEUSE

to take any:

	YES	NO
➤ Photographs	_____	_____
➤ Movies	_____	_____
➤ Tape-recordings	_____	_____
➤ Artwork	_____	_____

which faculty deem appropriate, and to utilize and publish them for medical, scientific and educational purposes, provided that reasonable precautions are taken to conserve anonymity.

However, I make the following restriction(s):

Signature of Patient or Guarantor

Date

Witness to Signature

Date

Appendix D

Group Description for Recruitment of Participants

For Use by Medical Staff and Internship Supervisor

Group: Relationship with the Self and Other Through Drama and Dance
(with Cindy Vielleuse, DT intern)

When: Tuesdays, 4:30-6 pm, beginning Jan. 27th

Duration: 6 weeks

For whom: Patients with anorexia nervosa or restricted eating

Contact: Cindy Vielleuse or Sally Cooke

Description: This group is aimed at patients with anorexia nervosa for the purpose of exploring, **1)** a healthy relationship with the self and a sense of body awareness and, **2)** the creation of positive interactions and bonds with others. One major hurdle in the recovery of anorexia nervosa is the individual's punitive relationship with the self, which may be impacted by, and contributing to, negative interpersonal relationships and social bonds. The concept of the *kinesphere* (the space that each individual occupies with their bodies) will be a main focus, approached through the use of **dance and movement exercises. Short improvisations, the creation of scenes, and the use of play** with a focus on personal and interpersonal relationships will also be addressed. Some exercises could trigger emotions which participants may find challenging but all issues will be approached in a supportive, non-threatening way.

This is a therapeutic group using mainly **experiential** methods. Opportunities for verbalizing will be given but sessions will focus on the use of embodied techniques, movement, play, etc. It is recommended that participants come prepared to move comfortably, avoiding constricting clothing. Participants are also strongly encouraged to commit to the six-week time frame to benefit from the entire therapeutic process, as each session will build on the last.

Confidentiality: All participant content will remain strictly confidential. However, participants should be informed that an academic paper will result that describes the overall therapeutic process of the group. Pseudonyms will be used if necessary and no identifying information will be included. Sessions will be videotaped in order to gather data. Video will be viewed only by me and will be destroyed at the completion of the project. **Video consent** should also be obtained.