

Adam's Body:

Playing with Bulimia and body image with a trauma-informed,  
critical race feminist drama therapy lens

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## Abstract

This paper presents an in-depth case review exploring the use of drama therapy with Adam; an adult in his early twenties who identified himself as a male person, a gay person, a person with Down syndrome, a racialized person, a “fat” person who has experienced fatphobia and a person with trauma and mental health issues including what appeared to be undiagnosed, mild Bulimia Nervosa. Fundamental to evaluating Adam’s case was an understanding of intersectionality, Michel Foucault’s theory of the deviant body, as well as the relationship between trauma and systemic violence. When Adam revealed that he had Bulimic behaviours and thought patterns as well as a negative body image, a thorough exploration of how Adam viewed his body and why was necessary before choosing a particular drama therapy intervention for Adam’s treatment. It became clear that because of Adam’s experience of multiple, overlapping marginalized identities, Adam had been exposed, long-term, to the punitive societal gaze, which was often embodied and enacted by important figures in his life. Adam seemed to have internalized this punitive gaze that translated to him regarding his body as defective, disgusting, tainted, and even morally wrong. It was by adopting a critical race feminist drama therapy frame that I was able to engage with Adam effectively. Through the drama therapy intervention of Developmental Transformations, I was able to play with Adam in the playspace and by doing so, engage him with his body and transform his traumatic material.

*Keywords:* Drama Therapy, Bulimia Nervosa, Intersectionality, the Deviant body, Developmental Transformations

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Adam is a person in his early twenties who identified himself as a male person, a gay person, a person with Down syndrome, a racialized person, a "fat" person who has experienced fatphobia and a person with trauma and mental health issues who has exhibited disordered eating behaviours. Adam disclosed to me that he was inducing vomiting after eating, through a variety of methods, approximately three times a week for a at least of period of three months, with the intention of losing weight because he believed that he was "fat". While Adam's mental health team did not assess Adam for Bulimia Nervosa and no diagnosis was ever made, this eating disordered behaviour and accompanying thought patterns were enough to shift my therapeutic exploration to Adam's lived-experience of what I will call undiagnosed, mild Bulimia. Adam soon revealed that his undiagnosed, mild Bulimia was coupled with very negative body image and low self-esteem, which became the focus of our second therapy series. Nisha Sajnani is the most prolific proponent of a critical race feminist paradigm in drama therapy. Sajnani (2011) details how a critical race feminist drama therapist might connect with, conceptualize, and write about a client:

For those in clinical practice, this paradigm offers helpful instruction in so far as it need for collaborative relationships based on a respect for our clients' wisdom about their own lived experiences and a willingness to make our values and assumptions transparent. It also emphasizes the need to cultivate an awareness of the social, cultural, and political experiences that have informed and continue to inform the ways in which we, along with our clients, live our processes of identification (p.189).

Political and social theory became integral to my adoption of Sajnani's critical race feminist paradigm. By adopting this lens, I was able to understand Adam's experience of his body as a result of many factors, but one of which was his traumatic experience with societal oppression. While working with Adam, it slowly emerged that Adam's complex, overlapping trauma had led to low self esteem which lead to poor body image which lead to body projects which took the form of bulimic behaviours. Why did Adam develop Bulimic behaviours, in particular? In the foreground, Adam has low impulse control combined with shame about his body and what is inside, while in the background, Adam became familiar with particular idealized bodies presented in popular culture - particularly through television. Laura Wood (2015), the foremost published drama therapist on the subject of eating disorders and drama therapy, argues that Developmental Transformations (DvT) can explore issues of shame and self-hatred by playing with subjects that are usually seen by the patient, and society at large, as unplayable. While playing with Adam, he was able to introduce the topic of his body, both the subject of his appearance and his bodily functions. Although Adam, at first, was adamant that his bodily functions (basic bodily functions, body liquids, and sexual organs and processes) were not natural and normal but rather, were disgusting and immoral, he soon developed the capacity to play with these topics with me in the DvT playspace. In this paper I will detail my two-year long exploration of the following questions: What might be some of the contributing factors to Adam's development of low self-esteem, negative body image, and undiagnosed, mild, Bulimia Nervosa and how might drama therapy be able to address Adam's treatment needs?

### **Theory**

The idea of intersectionality is fundamental to understanding Adam's experience of trauma. He has experienced repeated discrimination not just for one reason, or because of one characteristic, but because of many. These are chiefly ableism, racism, homophobia, and fatphobia. He experiences his own body as deviant precisely because he lives under the oppressive gaze.

### **Deviant bodies**

It is said that we live in a "disciplinary society" (Foucault, 1979, p.209) where the first stage of discipline is "the constant division between the normal and the abnormal" (Foucault, 1978, p.197). It is by calling a body abnormal that it becomes, as of that moment, deviant. As Samantha Murray states in her article, *Corporeal Knowledges and Deviant Bodies: Perceiving the Fat Body, Social Semiotics*, "If we imagine the spectre of normativity as a figure of desire and fear, it makes sense that we are driven by a fear of deviance, a fear that is supposed to position us carefully on the 'proper' side of the normal/deviant binary" (Murray, 2007, p.366). Jennifer Terry and Jacqueline Urla define the term 'embodied deviance' as "the historically and culturally specific belief that deviant social behavior...manifests in the materiality of the body... essentially marked in some recognizable fashion... Palpable and visible, the body's contours, ...and expressions are taken to be straightforward, accurate indications of an individual's essence and character" (S.Bryn Austin, 1999, p. 249). When Adam was also bullied for being racialized through racial slurs such as being called a "nigger" at school, one of the messages that was relayed was that Adam's 'blackness' was a major site of brokenness, taintedness, and dysfunction. Similarly, the way Adam was actively discriminated against for having Down Syndrome echoed these same message that Adam's body was flawed, deviant, and devalued as a less than human.

Laura Mulvey (1989) details the covert operations and impact of “the gaze” of, what Foucault would call, a punitive society. She explains that women have been coded as the passive sexual object meant to be imprinted on by the gaze of men. I would argue, however, that this “to-be-looked-at-ness” (p. 815) as a form of objectification can be identified in the experience of multiple marginalized and othered groups.

### **Sexuality and racism**

Foucault described the experience of the inescapable gaze of a homophobic society: one’s homosexuality is “everywhere present in him: at the root of all his actions because it was their insidious and indefinitely active principle; written immodestly on his face and body,” (Foucault, p.152). A contemporary example of a deviant body would be the ‘effeminate’ man – the man who does not perform his masculinity to the extent where all traces of more feminine qualities are annihilated. The ‘fat’ body and the excessively feminine body signify the utmost failure to perform contemporary gender roles in the context of sexuality. Adam’s gender performance has not allowed him to pass as strictly heterosexual or traditionally masculine and he has been punished for this by his peers through bullying. Body projects are essential to performing one’s gender as well as one’s sexual availability and sexual worth (Muray, 2007). These projects require people to tap into exclusive fields of knowledge of how to discipline one’s own body. As Foucault (1979) says: “In becoming the target of new mechanisms of power, the body is offered up to new forms of knowledge,” (p. 155) and it is this special knowledge that becomes an object of aspiration and desire. Adam looked to popular culture and in particular, Television shows to learn how his body should be, and how to begin a body project. Adam disclosed that he learned to

induce vomiting after eating as a method of weight loss from watching a favourite character from a Television show.

### **Ableism and fatphobia and body image**

Historically, the beauty industry has directed itself at the control and maintenance of women, but increasingly, it has been commodifying men – complicating the masculine beauty standard and intensifying the necessity to follow it. According to Murray (2007), 'Fatphobia,' for instance, is an issue which is beginning to affect men in a way similar to how it applies to women, particularly in regards to the construction of sexual attraction. Adam fixated on themes of sex, romantic love, and sexuality. Adam seemed to feel very aware that having Down syndrome and being 'fat' were inhibiting his ability to seem sexually attractive to other people.

Adam has many layers of trauma in his life, including traumatic events and experiences of abuse. However, Adam has also had to live under long term exposure to an oppressive, punitive gaze that consistently casts his body as deviant and sub-human. It was only through intersectionality theory, Foucault's theory of the deviant body, and Mulvey theory of the gaze that I was able to even begin to comprehend why Adam might view his body as disgusting and in need of augmentation and even punishment and pain.

## **Literature Review**

### **Bulimia Nervosa: A holistic summary**

As a clinician, I felt compelled to explore the etiology of Adam's body image issues and subsequent undiagnosed, mild Bulimia Nervosa before developing his treatment plan. Research into the etiology of eating disorders (Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder) as well as comparative studies on treating eating disorders (ED) remain relatively scarce. Decades

of research by the medical, psychiatric, and psychological communities have yielded no comprehensive conclusions as to what causes eating disorders. This has been decried as the failure of the field and there have been multiple calls for the need for more research into the etiology and treatment of eating disorders by some of the most prominent researchers currently studying in the field (Wilson, Grilo & Vitousek, 2007; Fairburn, 2005; Lock, Le Grange, Agras et al., 2010). Bulimia Nervosa is characterized by binge eating and compensatory behaviours such as purging but without being underweight (American Psychiatric Association, 2013). Bulimia Nervosa (BN) affects between 2-3% of adult women (Ferri, 2017). In 2013, recovery rates for Bulimia Nervosa were 55% within five years at a community level (Smirk et al., 2013). Although the mortality rates seem to be higher in people with Anorexia, the suicide rate for people with Bulimia is higher than the general population (American Psychiatric Association, 2013). Like patients with other eating disorders, patients with BN often have comorbid conditions (especially mood and anxiety disorders, but also problems with impulse control and substance abuse,) (American Psychiatric Association, 2013).

According to Memed Marmor (2016), Illing et al. (2010), and Abbate-Daga et al. (2010), the desire to be out of the body permeates the experience of almost each client and often the function of the eating disorder supports this goal. Furthermore, Carolyn Costin, author of *The Eating Disorder Sourcebook*, espouses that "Bulimics have described their symptoms as a way of purging the perpetrator, raging at the violator or oneself and getting rid of the filth or dirtiness inside of them" (p.68). Rice, Hardenbergh and Hornyak (1989) argue that it is a child's early experience of parental acceptance of their body that leads to a healthy body image. Should parental figures reject their child's body as defective and demonstrate in a number of ways, this



may lead to poor body image. (Rice, Hardenbergh & Hornyak, 1989). The article "Body and Self: The use of art therapy in eating disorder treatment" builds upon dance movement therapy when they identify:

sexual identity as one of six phases of body image development. This developmental milestone directly impacts an individual's body image, her or his capacity for intimacy, as well as her or his ability to practice differentiation, and it allows the person to experience the boundaries of their own body. Art therapy allows a person to experience pleasure in their body, have sensory awareness, develop boundaries, as well as experience integration in their body, sense of personal impact, and individuation (Memed Marmor, 2016, p. 170).

Hinz (2006), Malchiodi (2007), and Memed Marmor (2015) argue that the art therapy focus on process over product can facilitate the client's incorporation of mindfulness, being present and engaged in the body, or what I call inhabiting the body. These authors argue that this process-oriented approach does not emphasize an outcome or the appearance of the body but rather the pleasurable experience of the body. If art therapy can make a claim to an emphasis on process and embodiment, drama therapy most certainly must as well.

In their article, "Setting the stage for self-attunement: drama therapy as a guide for neural integration in the treatment of eating disorders," Wood and Schneider (2015), highlight how in the event that the client's insight is not enough to challenge well-established patterns of behavioural rigidity, embodiment and relational therapeutic techniques can help. The authors recall Jacobse's (1994) work when they highlight how patients with eating disorders often divide their mind from their body. They attempt to harness their mind to use as a tool of domination

against their body. It is drama therapy techniques that encourage the mind and body to work together as a whole.

### **Eating Disorders and trauma.**

In their book chapter, "Treatment of psychiatric comorbidities," (*The Treatment of Eating Disorders*) Steiger and Israel (2010) explore the relationship between trauma and eating disorders. They cite research that suggests that 30% of adults with eating disorders with bingeing and purging behaviours reported being sexually abused as children and 50% reported being physical abused during childhood. However, the authors highlight how few patients with eating disorders also meet criteria for a diagnosis of post-traumatic stress disorder (PTSD). This begs the question, whether trauma can manifest in other ways in these patients, including eating disorder behaviours. Steiger and Israel venture to argue that "past trauma may predict unfavourable treatment response or increased recidivism and relapse," (p. 451). They also call for the incorporation of trauma-informed interventions into eating disorder treatment, in the instance of comorbidity with PTSD. They recommend trauma treatment interventions such as cognitive restructuring, imaginal exposure, and desensitization. Steiger and Israel also call for specialized trauma-informed interventions for patients with eating disorders with comorbid PTSD.

Body image is a major component of the larger picture of someone with Bulimia Nervosa. Body image disturbance can be defined as "generally consisting of a subjective unhappiness with some aspect of one's appearance, is also extremely prevalent and may be associated with psychological distress (e.g., depression) and functional impairment (Thompson, 2001; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). A holistic approach to understanding eating disorders

supports exploring both the role of trauma as well as the history of body image disturbances in a person with an eating disorder.

### **Treatment**

This section presents a comprehensive summary of the most common contemporary eating disorder (ED) treatments (with a focus on Bulimia Nervosa) as well as the relationship between drama therapy and the treatment of eating disorders.

#### **Cognitive-Behavioural Therapy.**

In their article, “Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: an alternative to family therapy?” Dalle Grave, Calugi, Doll, and Fairburn (2013) critique Family-Based Treatment and offer Cognitive-Behavioural Therapy as an alternative. Cognitive-Behavioural Therapy (CBT) has long been the dominant form of evidence-based treatment for Bulimia Nervosa. Recently, there has been an observable drive within the ED research community to determine whether CBT has lasting results with patients with Anorexia Nervosa in both in-patient and out-patient settings. Dalle Grave et al. go on to describe a common modification of Cognitive-Behavioural Therapy for eating disorders as having three phases: 1) The introduction of new thinking about the patient's state and maintenance of that state; 2) A detailed analysis of the pros and cons of tackling their eating disorder. Then, when the patient is willing, a new emphasis is placed on gaining weight as well as the psychopathology of ED and the patient's concerns about shape and weight; 3) The focus is on helping the patient maintain these new changes (Dalle Grave, Calugi, Doll, & Fairburn, 2013). The subject of relapse is still a major focus for ED research and a conclusive treatment that prevents relapse has yet to be identified.

In their article, “Guided self-help CBT treatment for bulimic disorders: Effectiveness and clinically significant change,” Vaz, Conceição, and Machado (2013) attempt to better understand the effectiveness of Guided Self-Help CBT therapy with adults with Bulimia Nervosa. The authors argue that Guided Self-Help (GSH) can facilitate longer-term, intensive treatment. In the study, there were 42 adult participants with Bulimia or an eating disorder not otherwise specified (ED-NOS). Thirty participants completed the GSH treatment program and 24 of those participated in follow-up assessments, six months later. Vaz, Conceição, and Machado (2013) used pre and post-testing by employing the Eating Disorders Examination Questionnaire (EDE-Q) as well as the Beck Depression Inventory. For four to eight weeks, the participants would attend a 30-minute session, lead by a CBT therapist, where they would follow the GSH manual treatment plan. This manual focused on monitoring eating, behaviours and cognitions, eliminating dieting, problem-solving, emotional regulation, promoting self-esteem, changing belief systems about shape, weight, and food. The authors included a self-reporting survey where 58% of the participants said that they considered themselves much improved. According to the post-testing, there was clinically significant positive change in the majority of participants.

### **Psychodynamic and other psychotherapies.**

This section examines the recent studies that explore the use of Psychodynamic informed and Attachment therapy to treat eating disorders. Murphy, Russell, and Waller (2005) note that there is a marked lack of research determining whether psychodynamic therapy and other psychodynamic informed therapies are effective in the treatment of Bulimia Nervosa. In their study they implemented a psychodynamic and behavioral integrative treatment approach. Teresa Toto-Moriarty's (2012) notes that this psychodynamic/ behavioural integrative model is more

commonly accepted than psychodynamic informed psychotherapies alone. The authors cite the success of Interpersonal Therapy, which has psychodynamic origins, in treating Bulimia. Psychodynamic therapy places an emphasis on the therapeutic relationships as well as transference and countertransference. Murphy, Russell, and Waller (2005) highlight the modifications necessary when tailoring psychodynamic approaches to the treatment of eating disorders: the integration of behavioural therapy is crucial despite its divergence from psychodynamic and interpersonal therapy. The focus of this integrative therapy is to help the patient gain “a better understanding of themselves and patterns of relatedness” (Murphy et al., p. 384). In this pilot study, two groups of 21 adults with Bulimia and Binge Eating Disorder participated with a 3 month and 6 month follow-up. There were improvements across the board in both of the clinical groups. Murphy, Russell, and Waller (2005) highlight that, if these results were replicated in a larger sample, an integrative psychodynamic approach to eating disorder treatment may become more widely accepted.

In both in-patient and out-patient eating disorder care, there appears to be a drive within the current research to establish the most time-efficient treatment possible. One of Cognitive-Behavioral Therapy's edges on other more lengthy therapies is that many successful research studies are prescribing 20 weeks of therapy or less. Thompson-Brenner and Westen's (2005) study “A Naturalistic Study of Psychotherapy for Bulimia Nervosa: Comorbidity and Therapeutic Outcome,” addresses the time efficiency of eating disorder treatment in the context of comorbidity with other disorders. In many of the studies examined here, the researcher has opted to exclude patients who test positive for comorbidity with depression or anxiety, for instance. Thompson-Brenner and Westen unpack the effects that comorbidity has on treatment approaches

and time efficiency. Like Murphy et al., (2005), Thomson-Brenner and Westen highlight how psychodynamic as well as integrative or eclectic psychotherapies have yet to be tested with the same vigor as a treatment for eating disorders as CBT. They argue that this renders the declaration of CBT as the treatment of choice for Bulimia Nervosa, premature (Thompson-Brenner & Westen, 2005, p. 573). The authors undertake a naturalistic study in order to observe whether the results of randomized controlled trials translate into the clinical context. For their study, the authors collected systematic and quantified data from 103 clinicians (CBT, Psychodynamic, or Eclectic therapists) on their patients with Bulimia Nervosa. Through data analysis, the authors determined that clinicians had diagnosed over 90% of the sample with at least one comorbid disorder: 78.3% mood disorders; 57.6% anxiety disorders, (Thompson-Brenner & Westen, 2005, p. 578). The mean length of treatment was 97.8 weeks with the mean length before improvement was reported at 49.4 weeks, and the mean length before remission was reported at 66.8 weeks. Thompson-Brenner and Westen (2005) found that comorbidity in clients with Bulimia was the norm rather than the exception and that treatment plans for these clients take longer before improvement begins.

In their article, "Adolescent eating disorders: Treatment and response in a naturalistic study," Thompson-Brenner, Boisseau, and Satir (2010) collected data from clinicians about 120 adolescents with eating disorders. The authors determined that the average length of treatment to date for those patients who had recovered were significantly higher than those who had not recovered. Six forms of therapy interventions were identified: CBT, Family Intervention, Emotion regulation, Dynamic therapy, trauma therapy, and Conjoint treatment. CBT was used slightly most often, although, overall, the clinicians' approaches were eclectic, despite the lack of

evidence-based support for these other approaches. Eight months was the average length of treatment before significant improvements were observed by the clinicians.

In their article, "Attachment and Eating Disorders: A review of current research," Tasca and Balfour (2014) attempted to determine whether attachment insecurity is relevant to the field of eating disorders. They applied a standard attachment measure to pre-existing published case studies from between 2002 and 2014. Their results indicated that there were high rates of insecure attachment in patients with eating disorders. In addition, those who qualified as having avoidant attachment also had high rates of attrition. Tasca and Balfour (2014), argue that this conclusion places a renewed emphasis on the importance of the therapeutic alliance as well as psychodynamic approaches that take attachment theory into account. Teresa Toto-Moriarty's (2012) article, "A retrospective view of psychodynamic treatment: Perspectives of recovered bulimia nervosa patients" describes a qualitative, phenomenological study that uses naturalistic inquiry. In the study, the researcher conducted in-depth interviews with fourteen recovered female bulimic patients who had been in individual therapy that incorporated a psychodynamic approach. The participants had been in psychodynamic therapy for a minimum of two years and had terminated therapy no later than six months before the interviews. Five thematic categories were identified as part of recovery: 1) engagement and building the therapeutic alliance; 2) decoding the adaptive and psychological meaning of the symptom; 3) the nature of the therapy relationship; 4) signs of progress as the therapy work deepened; 5) adjunctive treatment approaches (Toto-Moriarty, p. 833). The author highlights the similarities between her findings and existing research but also notes the different themes that emerge when patients with eating disorders are asked directly about their experience rather than assessed through a series of numerical measures.

**Drama Therapy and Dance/Movement Therapy and Bulimia Nervosa.**

In their article, "Setting the stage for self-attunement: Drama therapy as a guide for neural integration in the treatment of eating disorders," Laura Wood and Christine Schneider (2015) describe the qualitative case-study of Cassandra, a 19-year old female with Bulimia Nervosa. The authors explain how they employed role-based drama therapy interventions as well as improvisation and psychodramatic techniques to help Cassandra improve her emotional regulation. According to Wood and Schneider, it is a lack of neural integration that contributes to two common experiences of people with eating disorders: 1) the rigidity that stems from consistently deferring to cognitive rules and rituals; 2) the experience of intense emotional chaos. The authors argue that an increase in neural integration would help people with eating disorders tolerate strong emotions. Wood and Schneider explain how drama therapy can address this by increasing self-attunement through the embodiment of emotions. According to Wood and Schneider (2015), in the event that the client's insight is not enough to challenge well-established patterns of behavioural rigidity, embodiment and relational therapeutic techniques can help. Wood espouses that drama therapy playspace can become a frame for patients' emotions and thoughts to play out and transform.

Anne M. Krantz (1999) examines a qualitative case study of a 24-year-old woman with Bulimia Nervosa. Krantz then presents a Dance/Movement Therapy model for the treatment of Bulimia and Anorexia. Krantz argues that "reconnecting the body with feelings allows the client to experience affect and express her inner world, to recognize meaning in her behavior and relationships, and to develop healthy psychophysical unity" (1999, p. 81). In her article, Krantz highlights the importance of addressing the underlying cultural, gender, and psychodynamic



conflicts that may exist in the eating-disordered patient. The emphasis on the client's relationship to their body is something that is heavily emphasized in this article but rarely touched on, if at all, in CBT or Psychodynamic Therapy based research.

In their article, "Body image therapy: a combined creative arts therapy and verbal psychotherapy approach," Kaslow and Eicher (1988) present multiple creative arts therapy interventions that can improve the body image of patients with eating disorders. These interventions include: metaphor and imagery work, sensory awareness, and projective artwork. Kaslow and Eicher (1988) highlight the drama therapy and dance/movement therapy technique of mirroring, noting the importance of including this technique in attachment work. The authors describe using improvisation as a form of embodied free association and highlight its therapeutic potential when working with patients with eating disorders. The authors argue that the best way to cultivate a positive and realistic body image with patients with anorexia nervosa, for instance, is to couple embodied exercises with verbal interventions. There are other drama therapy techniques that utilize mirroring, embodiment, improvisation, and work toward repairing attachment such as Developmental Transformations.

### **Developmental Transformations as treatment.**

In practice, DvT looks like a client and a therapist engaging in a free-flowing form of improvisation (Butler, 2012). There has been more and more research, of late indicating DvT as a trauma-informed drama therapy intervention for traumatized clients. DvT is based on the fundamental principle that the world is unstable. David Read Johnson (2009) argues that the human response to this instability "is to stabilize experience by reducing ambiguity and increasing order" (p. 70). DvT attempts to help people build "the capacity to remain balanced in unbalanced

situations” (Johnson, 2014, p. 70). Furthermore, Dvt is well-suited to trauma treatment because, in Dvt, the client is encouraged to play out their internal trauma schemas through the creative process (Johnson, 2014). In *Trauma Informed Drama Therapy*, written by David Read Johnson and Nisha Sajani (2014), Johnson (2014) and Pitre (2014) describe, in detail, how DvT can serve as a desensitization technique when working with traumatized clients. Developmental Transformations goes beyond active trauma treatment by simultaneously increasing the flexibility of the client as well as working towards repairing attachment.

As of yet, there are no publications that explicitly describe the use of DvT as a treatment for eating disorders. However, in 2015, Laura Wood contributed an article to the drama therapy forum, *Dramascope*, called "Building response flexibility in clients with eating disorders: Improvisation and embodying addiction" where she describes her success using Dvt in the treatment of eating disorders. In the article, Wood describes how the reactivity of many clients with eating disorders can result in an experience of the two extremes of rigidity and chaos. Wood argues that the play and creativity of DvT can help increase the patient's window of tolerance: which is to say, the patient's level of arousal to internal and external stimuli. Wood also highlights the relevance of Johnson's Recursive Interpersonal Process (noticing, feeling, animating, expressing) to engaging a patient's reactive tendencies. Although there is not yet any established research on the use of DvT with patients with eating disorders, it can be argued that the reasons why drama therapy can work in the treatment of eating disorders are the same reasons why DvT is well-suited to this task: it can help to increase flexibility, repair attachment, and act as trauma treatment.

Although there are multiple different therapeutic paradigms vying to be the preferred treatment for Eating Disorder, Cognitive Behavioral Therapy is dominating the field in both research studies and real results. The emphasis that the CBT research places on time efficiency for inpatient and outpatient treatment of eating disorders seems to be informed by the contemporary neoliberal global context. This emphasis on time efficiency may save governments and organizations money but it could also be distracting from more content-based inquiries about the long-term effectiveness of specific therapeutic interventions and paradigms. As it stands, the overall results of CBT treatment indicate that less than 50% of patients with Bulimia cease bingeing and purging upon completion of therapy (Toto-Moriarty, 2012; Wilson et al., 2007).

The hegemony of CBT seems to be further entrenching cognitive narratives of mind in contemporary conceptions of Eating Disorder treatment. Toto-Moriarty (2012) argues that “these studies evaluate treatment outcome based on physical and behavioral parameters, such as frequency of bingeing and purging, weight, and menses, excluding other characteristic features of the disorder, such as poor body image and self-esteem” (p. 845). The method seems to reinforce the disconnect between people’s internal drivers and lack of control over environmental factors. Two pillars of CBT are self-monitoring eating and in-session weighing (Fairburn et al., 2009; Thompson-Brenner & Westen 2010). These mechanisms of assessment theoretically have the adverse effect of further objectifying the body of the person with an eating disorder. The mind-body disintegration is commonly observed in clients with eating disorders (Wood & Schneider, 2015) and these methods may only further entrench these patterns. These underlying narratives are covert and have not been examined thoroughly through qualitative research.

### **Critical race feminist drama therapy**

To date, there has been a striking lack of critical race feminist discourse in the published sphere of the field of drama therapy (Sajjani, 2011; Johnson, 2009). Although there a number of drama therapists have referenced feminist theory in their publications, (Sajjani, 2011; Mayor, 2012; Dintino & Johnson, 1996; Hadley, 2006; Hogan, 1997; Jones, 2007; Wood, 2016) as well as critical race theory (Sajjani, 2011; Mayor, 2012), critical race feminist drama therapy has yet to rise within the dominant discourse. Nisha Sajjani (2011) explains that in critical race feminist theory, the personal is political: “oppression and power differences exist and are causes for psychological distress and illness. Therefore, in order to be effective, feminist therapists analyze the societal influences that negatively impact mental health and work to bring about social change alongside their clients; they may also work toward change in other areas of their lives” (p. 189). Sajjani (2011) calls for drama therapists to engage with this ‘response/ability’ further by articulating the politics of identification, representation, and witnessing in our process and performance-oriented work:

For those in clinical practice, this paradigm offers helpful instruction in so far as it need for collaborative relationships based on a respect for our clients’ wisdom about their own lived experiences and a willingness to make our values and assumptions transparent. It also emphasizes the need to cultivate an awareness of the social, cultural, and political experiences that have informed and continue to inform the ways in which we, along with our clients, live our processes of identification (p.189).

It was this theory of a critical race feminist drama therapy that informed my work with Adam and informs my narrative of his case.

### **Methodology**

This project is a qualitative exploration in the form of a first-person single-case review. I am reviewing Adam's case while closely following the case study method. A qualitative approach is necessary to thoroughly explore the research question: What might be some of the contributing factors to Adam's development of low self-esteem, negative body image, and undiagnosed, mild, Bulimia Nervosa and how might drama therapy be able to address Adam's treatment needs? This question not only invites but necessitates the inclusion of the researcher's personal and subjective interpretation and description of what they perceived as happening during the therapeutic series. It is the method of Case Study that best facilitates my description, evaluation, and observations of my client, Adam's, experience of doing Developmental Transformations.

### **Case Study**

Case Study method is a popular form of qualitative research across multiple disciplines and so there are many definitions of what a case study entails. David Aldridge (2005) defines case study method in the context of the creative arts therapies:

Case study designs are research strategies based upon empirical investigation. A particular case is identified and located in context, which may be social, temporal or spatial. It is the bounding of the case in a context that makes the case study a 'case' study – the case may be a person, several persons, a group or a situation (pp. 11).

In his chapter on Case Study method, in *The Sage Handbook of Qualitative Research*, Flyberg (2011) outlines the fundamental value of case study as a qualitative research methodology. He argues that case studies offer value to a larger research field because they provide a venue for rich, thick detail (unlike many other methodologies). He also argues that case studies can serve to

highlight exceptions and thus prevent falsification. Flyberg (2011) cites Karl Popper's famous example of the statement: 'All swans are white.' He highlights that this is falsification that can only be disproven by the discovery of a black swan. Just one deviant case falsifies the proposition that all swans are white. Many qualitative researchers who have written extensively on Case Study method agree that one of the most significant contributions of the Case Study method is that they serve to articulate and describe the exceptions that exist to the theory (Flyberg, 2011; Greenwood & Lowenthal, 2005; Baxter, 2008).

The postpositivist philosophical underpinnings of qualitative research acknowledge the inescapable presence of researcher bias and embrace the role of subjectivity. In Case Study method, the researcher is not encouraged to bracket (or to attempt to create the appearance of bracketing) their own experience. In light of this, this method is particularly fitting to describe a therapy series centered around the drama therapy intervention of Developmental Transformations for the very reason that DvT was built on the same philosophical foundation of the inextricability of subjectivity, as it applies to the therapeutic relationship in the DvT playspace. Case Study method acknowledges and accepts the active role of the researcher's subjective material in the research just as the drama therapy intervention of Developmental Transformations acknowledges and accepts the role of DvT therapist's own subjective material as they engage with their client (Johnson, 1992).

### **Method**

The particular method that informed this case study is a model developed by Aldridge and Aldridge (2008), called the Therapeutic Narrative Analysis. Rebecca Redhouse (2014), another

creative arts therapist, has simplified and applied Aldridge's five phase model in her case study as follows:

Phase 1: Gathering the material that will form the narrative.

Phase 2: Defining the setting in which the narrative occurred and within other theoretical ideas.

Phase 3: Identifying episodes for analysis. Generating a set of constructs which form the categories for analysis.

Phase 4: Analyzing the episodes according to contents and framework of constructs.

Phase 5: Synthesizing interpretations to form a therapeutic narrative\*.

\*Aldridge and Aldridge (2008) define the 'therapeutic narrative' as both a discourse and a way of understanding a therapeutic relationship or therapeutic series. According to Aldridge and Aldridge, the therapeutic narrative is co-constructed by therapist and the client. This term is helpful in the pursuit of a new language to describe case study research that does not misrepresent the therapist's interpretations as objective 'truth.'

### **Phase 1 and Phase 2.**

According to case study method, choosing the single case is a significant and formative step in the overall process. I have included this step as part of Phase 1 of Aldridge and Aldridge's model. This step included defining a bounded, single case of an adult in a particular community clinic where I was working as a drama therapist. The case is by definition bounded within space and time: the parameters of the case exist within the context of a major Canadian urban centre over the course of two therapeutic series spanning 14 months over the course of two years.. This case study describes a drama therapy series that included the drama therapy intervention, Developmental Transformations, over multiple sessions. When integrating Developmental

Transformations into the therapeutic series, the intention was to incorporate at least 15 minutes of DvT per session for as many of the 30 sessions as Adam agreed to. Phase 1 and 2 of Aldridge and Aldridge's model include data collection. My data was naturally occurring data that emerged during my therapy series with Adam, as part of my practicum placement at an outpatient clinic. My main source of data was my clinical notes. After each session, I wrote a detailed notes, describing what I noticed happening during the session. This included therapeutic interventions, drama therapy exercises and outcomes, client responses, disclosures, the development of the therapeutic alliance, and transference and countertransference, among other phenomena. I also included Adam's written work and artistic creations from our sessions. Another form of data that I included was information from Adam's medical charts.

### **Phase 3, Phase 4, and Phase 5.**

According to Aldridge and Aldridge's (2008) model, Phase 3, 4, and 5 involve deciding which events to include (and which to exclude) as well as the identification of themes. It is in these three phases where I adhered most carefully to Aldridge and Aldridge's model of data analysis and compilation. Aldridge and Aldridge (2008) describe the process of identifying, what they call 'episodes' from the therapy series. From these episodes I gleaned multiple key 'constructs' or themes. The next step was to develop a larger framework or big picture of the multiple constructs that I had identified. The final step was then to synthesize these interpretations to form a therapeutic narrative or what is commonly referred to as conclusions. Once the therapy series was completed and I had terminated with Adam, I began Phase 5, and by doing so I was able to reflect and synthesize outside the context of an ongoing therapy series.

### **Validity, reliability, and quality**



The primary purpose of this case review is to describe what I saw and my subjective interpretations of these events and images in order to construct and communicate a detail-rich narrative of Adam's case. This case study makes no claim to describe the lived experience of Adam. In his book, *Arts-Based Research*, Shaun McNiff (1998) engages with the postpositivist position of contemporary qualitative research to critique traditional notions of validity, reliability, and quality in research. He argues that "universal standards of validity may not be appropriate for many features of art therapy experience" (McNiff, 1998, p.160). McNiff espouses that the creative arts therapist's "feelings, perceptions, and interpretations of value" will always be present in their research and so the standards of scientific reliability do not apply in the same way to this field of clinical research. The subjectivity of the researcher as she engages with the therapy narrative of her client is much like the co-construction that takes place between the therapist and the client during Developmental Transformation and so the form and content of my inquiry are a fitting pair.

I have followed Aldridge and Aldridge's (2008) suggested questions to interrogate and explore my bias as a researcher and a therapist:

What are the paradigms of the philosophical concepts we subscribe to? What is the social and cultural context of our reflections and activities? What is our understanding of what it is to be human? What is our perspective of illness? How do we define the professional aspect of our therapeutic activities with regard to our personal values in general and in particular? What are our preconceptions? (p. 56).

I have included S. J. Tracy's (2010) methods of striving towards a new kind of quality in qualitative research. In her article, "Qualitative quality: Eight 'big-tent' criteria for excellent

qualitative research,” S. J. Tracy (2010) outlines an alternative model for quality in qualitative research. Tracy argues that her model contains within it enough flexibility to coexist with postpositivist critiques (McNiff, 1998; Denzin & Lincoln, 2005), of scientific standards of validity, reliability, and quality. I will evaluate my research through the lens of Tracy’s eight criteria for quality: a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence. I included my assessment of the various ways this case study might contribute to the field and where its shortcomings may lie, according to Tracy’s model.

### **Ethical Considerations**

I obtained informed consent both verbally and in written form from Adam to include him as my research subject. He consented to allow me to include all clinical data and personal observations and interpretations, including data that was created before his informed consent was obtained. Adam consented to my inclusion of all data including his written work and artistic creations, starting in September 2015, the beginning of our therapy series. Adam’s identity has been concealed through the use of a pseudonym, that he chose, as well as the active exclusion of any identifying information. I have adhered to the guidelines for research and confidentiality as outlined by the North American Drama Therapy Association Code of Ethical Principles. Finally, I recognize that there is a role conflict in the dual relationship between my responsibility to my client as his therapist and my commitment to my goals as a researcher. It is of the utmost importance that I privileged the needs and wishes of my client during his therapeutic process over my research goal to collect relevant data to further the research field in drama therapy. Throughout my therapeutic process with Adam, this was my intention and my approach.

### Case Review

Adam was referred to me by a therapy centre for adults with developmental disabilities in a large Canadian urban centre that focuses on creative art therapies, where I worked as an intern for a total of 18 months over a two-year period. Adam was referred to me for individual Drama Therapy in January, 2015 and our therapy series lasted until May, 2015. Adam was not referred to drama therapy for any particular pathology but was enrolled in a creative arts therapy program for three years and so was receiving art therapy, dance/movement therapy, musical therapy, and drama therapy at different times throughout the three year period. I continued working with Adam for a second therapy series from September, 2015 to May, 2016. Adam identifies as a cis-gendered male and he is in his early twenties. Adam has Down syndrome and has been diagnosed with a mild intellectual disability that has not been specified. Adam was also diagnosed with Sleep Apnea in 2013. Adam attended a high school for youth with intellectual disabilities but did not graduate. At the time of our therapy series, Adam was not involved in any other programming or work placements other than at the therapeutic centre where I saw him. Adam was referred to individual drama therapy because his recent behavioural issues became a concern at the centre and were suggested as one of my focuses in therapy with Adam. Adam's main behavioural issues consisted of talking about sex, body parts, and bodily functions even when his fellow participants and other therapist asked him to stop. Adam had also pulled down his pants, exposing his bare buttocks to one of the staff members at the center shortly before beginning therapy with me. Adam was also struggling in art therapy at the time, and was attempting to eat paint and was also smearing paint on his face as well as the rest of his body. Adam's impulsive

behaviour surrounding the subject of his body and eating had become a problem in art therapy as well as during lunchtime when he would reportedly binge at an all-you-can-eat style cafeteria.

Adam's developmental history remains unclear. The brief history that I had access to was accessed from Adam's psychologist as well as a brief interview conducted by the staff at the therapy centre with Adam's mother. Adam was diagnosed with Down Syndrome at birth and there was a developmental delay in his walking which began at age 2. Adam spent his early life living with his mother and his father. Adam also has a sister who is significantly older than him but who he visits often. Adam's parents divorced during Adam's adolescence. He sees his father very rarely. Upon accepting Adam into the therapy program, some behavioural issues were highlighted. During the intake interview, Adam's mother mentioned that Adam had been spending a great deal of time watching pornography. Adam said "I am addicted" during the interview. Adam's mother has said that he watches both homosexual porn as well as heterosexual porn. During the intake interview, Adam wrote on a piece of paper "I feel angry" and then he thoroughly crossed this out and replaced it by writing the word "happy" over and over, multiple times. It was also indicated in Adam's file that he often bites his hand. Since his acceptance to the centre, there have been multiple behavioural challenges with Adam. A major incident that occurred during February of 2014 has been the focus of much of the discussion of Adam by both his mother and the other practitioners at the therapy centre. Throughout our therapy series, Adam would bring this event up as a horrible time in his life. This incident and the events that followed seem to have been a traumatic event for Adam.

### **Traumatic event.**

## Adam's 2013/2014 Timeline

Date	Event
November 2013	Behavioural issues begin at school: being bullies and then aggression toward a staff member
December 2013	Diagnosed with Sleep Apnea
February 2014	Has his tonsils removed, begins taking oxycontin, Tylenol, and cough syrup post-operation.
February 2014	Incident*
March 2014	Admitted to a transitional home
July 2014	Returns to living with mother
October 2014	Begins attending the therapy centre
January 2015	Begins individual drama therapy

\*See description below.

\*The table above lists the events leading up to and following an incident that has been described in Adam's file as a 'psychotic break.' Adam's mother has described how during February, 2014 Adam had a reaction to the mixing of medications. The only medications that she mentioned were oxycontin, Tylenol, and cough syrup. It would appear that Adam was having a strong emotional or anxious reaction at the time of the incident: he allegedly attacked his mother (I am unclear as to his methods), and was looking around the house for a knife to cut his legs off.

That is how his “psychotic break” has been described. It would appear that within a few weeks, Adam was removed from his home and placed in a transitional care centre. He remained in different care centres until July 2014, when he moved back in with his mother. He began attending the centre three months after this transition. After this incident, Adam was put on Olanzapine, an atypical antipsychotic, used for the treatment of schizophrenia and bipolar disorder as well as Divalproex, which is also used for psychiatric conditions (Tohen et al., 2002). Adam uses 5 mg of Olanzapine as his PRN. Adam has been known to ask for his PRN, when highly agitated, while in group settings at the therapy Centre, although I never witnessed this. It became clear that Adam's challenges seemed to revolve around the theme of the body whether it be his behaviour at the center or his desire to cut his legs off while under extreme stress the previous winter. The emergence of these themes was what initially lead me towards wanting to know how Adam experiences his body and the bodies of others.

### **Summary of therapeutic process**

#### **Series 1: Bulimic behaviours and body dissatisfaction**

From the very beginning of the therapy series, I noticed that Adam would often describe various elements of his body or his bodily functions as disgusting. Adam seemed to hold these concepts as taboo and wrong. For instance, he would apologize profusely after burping or farting during the session and would then say “that's disgusting.” It appeared to me that he was echoing a common narrative of his family. Adam disclosed that he had bulimic behaviours and eating disorder thinking (e.g. drive for thinness) during a session in the middle of our first therapy series. This disclosure was, in part, provoked by my noticing and questioning in the here and now of the

session. During the check-in Adam brought up that he was gay (this was the second time that he had mentioned this). He then brought up how his favourite characters on television “kept secrets” and “told lies.” Adam seemed ever so slightly anxious and then asked to go to the washroom. He said he was feeling a little sick and then asked. He said it was because he didn't eat breakfast. I believe it was Adam's slight anxious affect that raised a quiet alarm in my mind. I waited for him to return from the washroom. When he did, I made a decision to see if I could explore a bit more the fact that he had gone to the washroom. I asked Adam: “Does your stomach still hurt?” and he said yes. He then offered that he had indeed eaten breakfast and that his mother had taken him to MacDonald's. I then asked him whether his stomach often hurt after he ate. He said yes. I asked him as gently as I could, whether he had puked in the washroom. He said that yes, he had. He then offered that he needs to lose weight because he's fat. I eventually asked him whether he pukes often after eating and he said yes. He told about how he binges and feels that he can't control himself when he is around food. Adam then explained that he purges. It appeared to me that Adam may have an eating disorder and if so, he may have bulimia. During the next session, I was able to follow-up with Adam and ask further questions about his bingeing and purging. He volunteered that he was bingeing and purging in the hope of losing weight because of his belief that he was “fat” at least three times a week. It was unclear as to whether the bingeing and purging had been going on for three months or less. Adam seemed to be struggling to remember the timeline as we discussed this. I then asked for Adam's consent to consult with his psychologist about the bingeing and purging and he consented. I immediately informed Adam's psychologist but it was unclear as to whether he planned to address this with Adam or not and no diagnosis of an eating disorder was ever made. Shortly after the disclosure, I asked Adam whether he had ever

had sex before and he said no. I then asked whether anyone had ever touched him in his private parts like his penis or asked him to touch them in a sexual way and he said no. This was my attempt to rule out sexual abuse as one of the precursors to Adam's preoccupation with his body as tainted, disgusting, and highly sexual. Of course, sexual abuse can be never be truly ruled out but Adam denied having had ever experienced sexual abuse when I directly asked him.

Adam's mother mentioned his weight and size as a problem multiple times during the interview that she gave at the therapy centre. His weight was also mentioned in his intake form and in the notes from a previous interview. Adam's mother reported that Adam's weight gain had taken place after he began his anti-psychotic drug, less than a year ago. During Adam's initial disclosure of the bingeing and purging, I asked him if anyone had ever called him fat before? He said yes, that his mother had. I asked Adam whether he thought that he was fat or if it was his mother who thought that. He said that it was his mom. On paper, he listed all the things that his mom and others had told him about his weight. Then we created a list of the things he thought about his weight. He said he thought his body was okay. He said he wanted to be okay with himself just the way he was. Adam told me about a scene in *Pretty Little Liars* where his favourite character helps another girl (who is bulimic) vomit after eating. I asked Adam whether he thought this girl was being a good friend or a bad friend and he said that she thought she was being a good friend. I tried to affirm him and to tell him that this is something we can work on together in therapy.

### **Treatment**

This is when I developed a six session treatment plan for Adam that consisted of 20 minutes of Developmental Transformations. Although Adam seemed most comfortable sitting



and writing with me, I wanted to see if I could challenge him into more embodied work. Adam seemed to like to move but not in the playspace, specifically. I believed that in light of Adam's undiagnosed mild eating disorder and negative body image, more embodied play might have been the very place to go therapeutically. I wanted to attempt the drama therapy concept of externalizing or 'playing out' internal desires and conflicts (Jones, 2007). Because Developmental Transformations is a "transformation of embodied encounters in the playspace" (Johnson, 2009, p. 89), it is the perfect drama therapy intervention to both challenge and hold Adam as he navigated his impulsiveness. In Laura Wood's 2015 online article entitled "Building response flexibility in clients with eating disorders: Improvisation and embodying addiction," she argues that DvT can explore the issues of shame and self-hate by playing with subjects that are usually seen by the patient, and society at large, as unplayable or taboo. It was the deviant qualities of Adam's body that seemed to be the most unplayable for Adam including his weight and shape, his bodily fluids, and his organs or processes connected to his sexuality. DvT seemed to be the perfect drama therapy intervention to facilitate transformation in Adam's experience of himself as wholly deviant.

### **DvT session example.**

This is a description of a Developmental Transformations session that I have constructed from detailed notes taken directly after the session on April 27th, 2015. This is the record and analysis of an individual DvT session between me as the player and Adam. This was the sixth session where we had incorporated at least fifteen minutes of DvT as part of a ten session DvT series. At the time of this session, I had been engaged in individual drama therapy with Adam for four months.

I began this session by asking Adam whether he wanted to begin with a movement or a sound and a movement or by taking on a sculpt, or sculpting me.

Adam: Meow, meow. (Adam began with what seemed to me like cat-like sounds.)

Charlotte: Meow, meow, meow. (I joined in the cat-like mewling and tried to match a languid movement to my cat sounds.)

Adam: Meow, meow. (Adam begins a slow cat-like wriggling movement.)

Charlotte: Meow, meow, meow (with same slow cat-like movement, moving towards Adam slightly. I was intensifying Adam's meow and movement here.)

Adam: Stop! Let's be dogs.

Charlotte: Ruff, Ruff! (With more of a bouncing movement.)

Adam: Ruff, ruff, ruff! (With a similar bouncing movement.)

Charlotte: Ruff, ruff, ruff! (With the same bouncing movement but also a playful movement forward as if trying to invite Adam as the dog to play.)

Adam: Stop! Let's be birds!

Charlotte: Okay, birds! (Noticing Adam's slow flapping motion) Wow... What kind of bird are you?

Adam: A yellow, calm, flying bird. What are you?

Charlotte: (flapping, in a more sporadic, quick way) Caw, caw! I am a blue bird.

Adam: Caw, Caw. I'm a seagull now. I hate seagulls.

Charlotte: Caw! Caw! (Attempting to screech like a seagull.)

Adam: Ahhhhh! (He screams, playfully and runs away to the other side of the playspace.)

Stop.

Charlotte: Okay. What do you want to be now?

Adam: Nothing.

Charlotte: Nothing? Well do you want to be an animal or a human?

Adam: A police officer. You are a robber!

Charlotte: (I began to run away from Adam. He chased me.) Ahhhhhh! (I let Adam catch me). Okay, okay, you caught me. I surrender. (Adam handcuffs me).

Adam: I'm going to drive you to jail.

Charlotte: Listen, Sir. I am a changed man. I am good now. Please? Please let me go. I swear I've changed.

Adam: Okay... okay. (He undoes my handcuffs. I immediately run away, laughing gleefully.) Wahhhhh! (Adam seemed surprised and betrayed, as the police officer.)

He chased me but then sat in the middle of the play space and said he had failed. He then said he would shoot me. I froze. Then he said no he wouldn't so I gleefully continued to steal. Then he said he would shoot me again so I froze. Then he got up and locked me up again. Then I asked if he would be the robber. This seemed to be a controversial idea but he agreed to it and ran around stealing imaginary versions of my real things. I caught him physically and took him to jail but made myself a coffee before putting him in the sell. He stole my keys and escaped. I sat down and said that I had failed and he offered to give me back my keys. I asked whether he preferred being locked up or being free. He said being free. Then he stole my imaginary glasses and I chased him around blindly. He offered to give them back and it was clear that I would put him in jail if he did. He said he wanted to be free. I made him a deal. He said he wanted me to make him coffee in exchange. I did. He then said he wanted a donut. I said he could have 5 and I threw them to him.

He caught them one by one and ate them. I asked if he was full and he said more so I threw many, many more to him until he said stop, stop he was done. Then he said he was fat. I said that I was a fat police officer because I had a beer belly because I went to the bar every day after work. I showed him my larger than life beer belly. I asked him to show me his larger than life one too. He mimed it as well. I said we should walk with our giant bellies and we did. He lay down on the floor. He said he had to throw up. I lay down too. Then he said that he died. I asked what was the cause of death and he said from being fat. I became the mortician to determine the cause of death. He jumped up to join me. I gave him a science lab coat. I said that the rumoured cause of death was from being fat but we wanted to be sure as scientists. I asked what's tools we would need he said a knife. He wanted to cut the stomach open. He said he was disgusted by it and ran away. I made it spurt lots of blood. There were donuts in there. He wanted to throw the body to the sharks. We did. I took a picture of his stomach before we dumped the body. We then examined the picture. He said he also saw jewelry and boots in there. They had been stolen. He said he ate them because he stole them. I said that I thought we had a new cause of death. That he died from eating those objects that are not food.

### **Therapy Series 2: Sexuality and advocacy**

#### **Beginning phase of second series: session 1 to 7.**

Upon beginning Adam's second individual drama therapy series, he was able to acclimatize to the modality rapidly and enthusiastically. The main focus of the beginning phase of this second series was to rediscover a strong therapeutic alliance as well as to reassess Adam's current goals. The major theme that emerged from the first phase of therapy was, again, sexuality and the body. I asked Adam directly about whether he was still inducing vomiting after eating and when was the

last time he had done this. He reported that the last time was in the spring of 2015, during our first therapy series. Adam seemed to want to continue to explore themes surrounding the notion of the body such as sex, body image, weight, gender identity, gender performance, and power. In light of Adam's emphasis on the themes of sex, we explored these themes through talking as well as some direct psychoeducation about consent. We explored themes such as sexuality, loneliness, connection, friendship, and acceptance through improvised scenes that either centered around dating or Adam's chosen television shows: *Pretty Little Liars* and *H2O*. These shows were an excellent vehicle to explore these themes through improvisation. Another major theme that emerged was the notion of adult needs (including sex and human connection) and how to get one's needs fulfilled. I chose to frame Adam's experience of desire through a needs framework in order to validate his sexuality and sexual orientation as normal and natural.

After the Holiday break, Adam was able to reiterate his self-generated goals for therapy including working on body image and to talk more about sex. Adam asked for a meeting with his psychologist, his mother, and I to discuss a list of adult needs including sex. It appeared to me that Adam wanted his mother to change her perspective on his interest in porn, desires to go on dates, and his sexual orientation. After confirming this wish with Adam multiple times, I organized the meeting. Adam's interest in sexual themes seemed to intensify his experience of erotic transference towards me, as his therapist, and so we often discussed such topics as the nature of our therapeutic relationship, consent, and Adam's strong and understandable desire to connect. I stressed the importance of consensual touch and respecting other people's boundaries as well as his own. These interventions seemed to be helpful and our therapeutic alliance continued to strengthen through the series. In addition to validating Adam's need for sex, I was able to also

highlight how Adam's preoccupation with touch might be a desire to connect with people. We worked on all the ways people can connect without sexual touch. I was sure to validate Adam's sadness about being unfulfilled sexually and inexperienced romantically. During this phase of therapy, Adam explored race and his experience as a racialized body who has experienced racism, through drawing. He also explored his experience as a queer, bisexual, or gay person through drawing black penises and black men having sex with each other. I continued to validate this body parts and sexual acts as natural and normal. Adam disclosed that he had been bullied and discriminated against because of his race and his sexual orientation. During this phase of the therapy series, it became clear that Adam seemed to have an internalized religious authority figure(s) with an over-critical perspective on sex, the body, pornography and bodily functions. Adam expressed that these themes were connected to the devil and were the reason he may be going to hell. It was through drama therapy interventions such as improvisation and DvT that Adam and I were able to validate his body.

During the final phase of therapy, Adam and I continued to work with his erotic transference and focus on sexuality by exploring consent and as well as needs-based approach of his experience. We explored through both talk interventions as well as improvised scene work Adam's need for his sexual orientation as well as his sexuality to be witnessed and accepted. Adam created a scene where two gay men were on a date. Adam also requested that we have a fashion show and so we created a fashion show complete with costumes, makeup, high-heeled shoes, hair, and music where Adam enrolled as a feminine female. During this phase of the therapy series Adam began to disclose his feelings about his family and his parents' divorce, for

the first time. It was during a couple sessions of DvT toward the end of the therapy series when Adam played with themes of attachment, connection, and acceptance.

### **Termination**

Adam and I spent the final five sessions on termination. I made sure to include multiple closing rituals to help Adam understand the termination and understand that I accept all of his feelings and qualities. During this phase of the series Adam asked for future therapy and seemed particularly enthusiastic about the idea of seeing a family therapist with his mother in order to better facilitate communication about his needs and experiences.

### **Progress**

During this therapy series, Adam made significant progress towards his goals. He was able to develop and employ healthy coping mechanisms during moments of emotional flooding. He practiced articulating his emotions with significantly less shame than during the beginning of the series. Adam was able to begin the process of internalizing that his adult needs, including those around sex and connection are natural and normal. Adam was able to engage in conversation about themes that normally activate him, such as sex, bodily functions, and his body, with much less shame and anxiety than at the beginning of the series. During the series, Adam initiated and expressed a desire to advocate for himself at a meeting with his mother and his psychologist as well as a desire to engage in a series of family therapy as means of improving his home life. Before terminating with Adam, I was able to advocate for him one final time by responding to his request for family therapy by recommending this for his future treatment at the therapy centre where he will continue for one more year.

### **Discussion**

When Adam told me that he view his body as disgusting - a belief that he would repeatedly demonstrate in play - my critical race feminist drama therapy framework allowed me to explore the variety of places and ways Adam might have received this message. Although it was clear that Adam's mother had been a key player in emphasizing Adam's weight, size, and body as dissatisfactory, I wondered how she and the other people in Adam's life learned about the body. When Adam disclosed that he had been bullied in school for being gay, for being black, and for being "fat," it occurred to me that Adam's experience of the punitive gaze was layered and ongoing and more pervasive than the problematic relationship with his body and his mother. It was a critical race feminist lens that allowed me to analyze how in society, Adam's body is, in fact, coded as deviant and defective because of his Down syndrome, high 'blackness,' his 'gayness,' and his size and shape. According to critical race feminist theory, Adam had accurately interpreted society's categorization of his body and internalized the message that he was defective as truth. It was my trauma-informed frame that allowed me to qualify Adam's prolonged exposure to discrimination based on his multiple marginalized identities, both within his immediate family and without, as a trauma. It was by using both a trauma-informed and critical race feminist lens that I was able to answer my initial research question: What might be some of the contributing factors to Adam's development of low self-esteem, negative body image, and undiagnosed, mild, Bulimia Nervosa and how might drama therapy be able to address Adam's treatment needs? It was because I identified the key process of Adam's internalization of a societal, punitive gaze, that I was able to apply a helpful treatment plan which included Developmental Transformations - an intervention that is helpful for both trauma treatment and trauma associated with the body.

### **Conclusion**



Moving forward, I would call for the intentional integration of the lens of intersectionality for the field of drama therapy, when endeavouring to assess, analyze, and treat clients. One cannot thoroughly assess someone's trauma history if one only includes certain 'events' such as car accidents and hurricanes or even child abuse or sexual assault as trauma. Trauma is relational, complex, and often layered and does not only occur from person to person but has often also occurred between the person and the social systems of classism, sexism, racism, homophobia, ableism, sizeism, and ageism. I would echo Nisha Sajjani's (2012) call for the adoption of a critical race feminist paradigm in drama therapy so that our clients' experiences of trauma at the hands of systemic violence will not go unacknowledged and thus, untreated.

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