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SETTING THE STAGE FOR RECOVERY: A PRACTICAL USE OF DANCE/MOVEMENT
THERAPY IN LATE STAGE EATING DISORDER RECOVERY

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ABSTRACT

Recovery from eating disorders, such as anorexia nervosa, bulimia nervosa, and binge eating disorder, is a continuous process that spans over a lifetime. The stages of change model used in treating substance abuse is applicable for recovery from eating disorders. This is reflected through the development of adaptive skills and behaviors, such as increased self-awareness, increased frustration tolerance, decreased anxiety, and the establishment of boundaries, as recovery progresses.

Dance/movement therapy is a beneficial therapeutic means to utilize throughout the recovery process. Due to the developmental nature of recovery, dance/movement therapy techniques, such as breath support, rhythm, role-playing, and imagery, are adapted to reflect the growth of those in later stages versus those in earlier stages of recovery. Modifications of these techniques expand upon developing knowledge and skills and support the transition from treatment to adjusting to everyday life.

Keywords: dance/movement therapy, eating disorder, recovery, stages of change, late stage recovery

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. Eating disorder recovery is a lifelong experience that continues long after initial treatment due to the body's natural necessity for food as nourishment. The process of accepting food as a basic human need while learning to navigate one's emotional response to this fact post-eating disorder requires facing complex emotions, unlearning negative thinking patterns, and adopting healthy habits.

To begin understanding the importance of recovery, it is important first to have an understanding of the nature of an eating disorder. Eating disorders are categorized by a preoccupation with food and body weight, as well as thoughts and emotions relating to body image and perception of food. There are three different types of eating disorders, anorexia nervosa, bulimia nervosa, and binge eating disorder, each with marked differences in symptomatology, presentation, and diagnostic criteria. One of the main symptoms of anorexia nervosa is limiting calorie intake by restricting how much one eats. This leads to a low body weight that is significantly less than what is considered "average" for the person's height and age group. Another symptom is fear of gaining weight. This intense fear leads to behaviors to contribute to weight loss or interfere with weight gain. Examples of behaviors that interfere with weight gain include dieting, excessive exercise, or taking laxatives when not medically necessary. The last major symptom of anorexia nervosa is a disturbance in the way the person experiences their body. For example, one may be visibly significantly undernourished, but still perceive themselves as being bigger. A person with anorexia will often feel unsatisfied with their body based on these unrealistic perceptions. They may also be unable to recognize the severity of their low body weight, despite what others tell them. This denial can lead to a misunderstanding of concern for their safety as encouragement to continue losing weight. It can also potentially be

understood as jealousy from the person expressing concern as the person with anorexia may understand the concern as criticism driven by their loved one's desire to reach these same unrealistic body goals (American Psychiatric Association, 2013).

While anorexia nervosa is more commonly diagnosed in female adolescents and young adults, eating disorders of any kind can be experienced by anyone regardless of body type, age, gender, race, ethnicity, social class, sexuality, or religion. Certain populations, such as men, may face more stigma around eating disorders as female adolescents are the population with the most prevalence of eating disorders. Older women and people with curvier body types may also have a harder time receiving this diagnosis based on societal understandings of what a person with anorexia typically looks like. Additionally, lack of funding for eating disorder prevention and recovery can lead to complications in diagnosis and treatment for those from low socio-economic backgrounds. Because of the lack of understanding about eating disorders and the impact they have on those affected, there is some question around what medical or psychological interventions are necessary for recovery, leading to lack of monetary funding from insurance companies and other supportive medical institutions. Therefore, access to treatment options, particularly for those from lower socioeconomic backgrounds, is decreased. This can lead to reduced treatment options as well as further damage from eating disorder behaviors and beliefs, resulting in decreased quality of life and potentially death (American Psychological Association, 2013).

Bulimia nervosa is another type of eating disorder characterized by repeated binge eating episodes that occur within a fixed, limited period of time. Within this period, generally within one to two hours, the person will eat significantly more than what most people would eat in a similar amount of time. During these periods, the person will exhibit a feeling of lack of control

over how much they are eating. This means that during a binge eating episode, a person with bulimia nervosa will compulsively eat large quantities of food and feel as though they cannot stop or slow down. Along with binge eating episodes, a person who fits the diagnosis for bulimia nervosa will engage in behaviors believed to prevent themselves from gaining weight. This is often referred to as “purging” and can be done in a number of ways, such as making oneself vomit, using laxatives when not medically necessary, and engaging in excessive exercising. The bingeing and purging behaviors will occur at least once a week over a period of three months. Another criterion for diagnosis of bulimia nervosa is self-evaluation based on one’s feelings toward their body shape and weight. This is similar to the criteria for anorexia nervosa, highlighting the psychological impact of eating disorders in relation to body image (American Psychological Association, 2013).

Similar to anorexia nervosa, the average onset of bulimia nervosa is in adolescence and early adulthood. It is more commonly observed in females than males. Bulimia is often detected after periods of dieting or restricting food intake with the intention to lose weight. Like anorexia nervosa, bulimia nervosa is often triggered by stressful or traumatic events that result in the sufferer feeling hopeless or as though they have no control over the situation (American Psychological Association, 2013).

Binge-Eating Disorder (BED) is an eating disorder categorized by eating large amounts of foods within a fixed period of time, as well as a felt lack of control surrounding overeating during this fixed period of time. This is similar to the first criterion described for bulimia nervosa. However, rather than dispelling the abundance of food in some way, a person with binge-eating disorder will not engage in purging behaviors. Instead, a person with binge-eating disorder will eat when they are not hungry, will feel uncomfortably full after an episode of binge

eating, will eat alone out of embarrassment of how much they are eating, and have feelings of guilt or disgust with oneself after a binge-eating episode. As in bulimia nervosa, these behaviors will be present at least once a week during a three-month period (American Psychological Association, 2013).

Compared to anorexia nervosa and bulimia nervosa, there is less of a difference between the prevalence of binge-eating disorder between males and females. There is also a more equal prevalence between people of color and white people experiencing binge-eating disorder. While cultural identifiers do not appear to predict whether someone will be diagnosed with binge-eating disorder or not, it is worth noting that BED is more common in individuals who are searching for treatment for weight loss than for those in the general population. In contrast to the belief that anorexia nervosa and bulimia nervosa are triggered by stressful or traumatic events, there is little known about how BED is developed in those with the diagnosis. In regard to diagnosis and treatment, BED often begins developing in adolescence and early adulthood, though it can develop at any age, and people are often in early adulthood when they seek treatment for the disorder (American Psychological Association, 2013).

Eating disorders are body-based illnesses that impact the affected person physically, mentally, and emotionally. Physically, a person with an eating disorder will experience changes in weight, either an increase or a decrease. The weight change itself, as well as the behaviors that contribute to the weight change, can potentially lead to increased risk of heart complications, amenorrhea (loss of menstrual period) in people with female reproductive organs, Type 2 diabetes, bone thinning, tooth decay, dizziness, hormonal imbalances, as well as many other potentially life-threatening complications. (American Psychological Association, 2013).

A person with an eating disorder may experience psychological symptoms as well one of which is poor body image. Body image is one's mental perception of their body. Factors such as feedback from others, media influence, childhood experiences, parents' and grandparents' attitudes toward their bodies, and one's own internal emotions, beliefs, and moods can contribute to one's body image. Each of these elements plays a role in how people perceive themselves. In people with eating disorders, poor body image is often reported. Poor body image contributes to the continuation of eating disorder behaviors, with the belief that one may improve their body image by altering their eating habits (Sarwer and Polonsky, 2016).

Self-esteem is also shown to be lower in people with eating disorders. Self-esteem and body image are similar in that they are a reflection of one's own perceptions of themselves. However, while body image is a person's attitude towards their body, self-esteem is related to one's perception of their overall worth. Self-esteem is impacted by feedback from others, success in academics or career, platonic and romantic relationships, and one's mental health (Orth et al, 2018).

Other psychological impacts of eating disorders include the practice food-related rituals that can consume much time and energy. Examples of food rituals include cutting food a certain number of times before eating it, chewing food a specific number of times before swallowing, separating different foods from touching on a plate, eating meals alone, standing while eating, or eating in a set time frame. Other psychological impacts are sleep disturbances due to hunger or anxiety, increased isolation, depressed mood, and anxiety around mealtimes. A person with an eating disorder will often deny that they have a problem, despite experiencing life-threatening symptoms. Eating disorders are often comorbid with other mental illnesses such as mood

disorders, anxiety disorders, and obsessive-compulsive disorders. (American Psychological Association, 2013).

The role of denial in treating an eating disorder is an important one to address and addressing it may be an ongoing process. A person with an eating disorder will often deny that they have a problem, despite experiencing life-threatening symptoms, thus making it harder to treat their symptoms. As mentioned earlier in this paper, denial of the severity or the presence of symptoms can impact the perception of the affected person (American Psychological Association, 2013). Concern can be understood as encouragement or as jealousy. Due to the skewed understanding of the reality of the disorder, confronting the denial and conducting frequent reality checks is beneficial to the process of treating people with eating disorders, however it can often be a hard obstacle to overcome as it is ingrained throughout the person's experience. Denial of symptoms is only one way that denial plays a role in eating disorder treatment. It can surface whenever the person with an eating disorder hears a comment related to their recovery, when learning a new positive coping skill in treatment, or when sitting down for a meal. Because the person likely views their eating disorder as a way to cope with stressful situations, they often believe that learning more positive behaviors in place of the maladaptive behaviors is a threat to their familiar coping mechanism and will defend it with denial that the new positive behaviors will be beneficial (Latimer and Schwalen, 2016).

The root of denial in people with eating disorders, and in loved ones of people with eating disorders, is fear (Latimer and Schwalen, 2016). It is hard to face the reality of destructive behaviors but believing there is no problem protects people from the realities of eating disorders. Doing so only strengthens the denial and makes it harder to recover from an eating disorder. When family members or other loved ones participate in the denial, it is their own way of coping

with their loved one's eating disorder. However, it is also enabling the behavior. Some examples of this include believing that there is an underlying medical condition leading to the weight loss, changing meal routines and preparation to support the person with an eating disorder in hopes that they will eat if the existing meal time practices change, and making excuses for the maladaptive behaviors (Latimer and Schwalen, 2016).

Eating disorders are often comorbid with other mental illnesses such as mood disorders, anxiety disorders, and obsessive-compulsive disorders, as well as other feeding and eating disorders. This means that an eating disorder can be present alongside another mental illness. The presence of co-occurring illnesses can make treatment increasingly difficult as the symptomology becomes more complex than that of a singular eating disorder. Because of this, recovery may also be more difficult to maintain due to the range of symptoms present (American Psychological Association, 2013).

Because eating disorders can affect people in a range of different cultures and backgrounds, the presentation of eating disorders looks different from person to person. For example, while two people could fit the criteria to be diagnosed with anorexia nervosa, they may have different symptoms, the pacing of the onset of the disorder could be faster or slower, or the same symptoms may present differently for each person. An example of this is if two patients present the behavioral symptom of practicing ritualistic eating patterns, meaning they are exhibiting compulsive interactions with food to avoid the anxiety that would occur if this action was not completed in a way that was satisfactory to the person, but their ritual is different. One patient's ritualistic eating pattern consists of arranging food on their plate so that none of the different foods are touching. Meanwhile, another patient's ritual is chewing their food a certain number of times before swallowing it. Both of these are examples of the same symptom,

ritualistic eating patterns, but it is presented differently in both patients due to their unique circumstances and unique beliefs around food (Center for Discovery).

Much like the uniqueness of the symptoms of an eating disorder for each individual affected by one, the treatment of eating disorders is also unique to cater to the needs of each patient. Different modalities of treatment as well as different philosophical approaches will be useful for different people. To treat an eating disorder, it is common for the affected person to have a treatment team composed of a general practitioner to monitor physical health, a dietitian to educate the patient about the importance of proper nutrition and to co-create a meal plan that the patient is comfortable with to exemplify positive eating habits, a psychologist to help the patient work through their presenting problems in a confidential space, and a psychiatrist to handle medication management should psychiatric medication be necessary. Depending on the needs of the person with an eating disorder, greater or fewer members of the team may be necessary. For example, a psychiatrist may or may not be necessary to include in a treatment team based on the severity of symptoms and the effectiveness of other forms of treatment provided by the general practitioner, dietitian, and psychologist. With the combined medical and psychological approaches to treatment, a person is better able to recover from both the physical and psychological facets of eating disorders with the help of the professional who is most equipped to help monitor their progress at reducing their symptoms. The team works together with the person with an eating disorder to help work toward regaining physical and psychological health. There are different modes of treatment, including routine physicals with a general practitioner, nutrition education and meal plan assistance from a dietitian, various forms of psychotherapy, and psychiatric medication management. Treatment can take place in outpatient or inpatient contexts, depending on the severity of the disorder and the needs of the

patient. More severe symptoms often require inpatient treatment as the patient may benefit from more frequent monitoring of their health. Inpatient facilities offer more structure in terms of scheduled groups and mealtimes which offers consistency in establishing healthier habits as well as an organized system that can be comforting to those who practice rituals or struggle from obsessive-compulsive beliefs (American Dietetic Association, 2006).

Recovery does not happen all at once. Keski-Rahkonen and Tozzi (2005) adapted a recovery model previously used for substance abuse to assess the stages of eating disorder recovery. Here, it will be applied to eating disorder recovery as well. The recovery process for eating disorders is similar to the recovery process of substance abuse. The theme of coping with emotions by displacing them onto a source outside the body, such as food or substances, is a common thread between both substance abuse and eating disorders. These illnesses also share themes of denial that there is a problem, as well as a forming of unhealthy habits or addictions. Because of these common factors, it has been shown that the stages of change model for substance abuse is also applicable to eating disorder recovery.

The first stage of recovery is pre-contemplation, where the person with an eating disorder may be experiencing the negative effects of their eating disorder, but not be able to recognize that the effects are more harmful than helpful. These negative effects include social isolation due to obsessive and compulsive behaviors around meal times, lack of energy, depressed mood, and loss of interest in activities that they once enjoyed. Despite experiencing undesirable effects, without recognizing the negative impact, there is no intention to change at this stage. In this stage, a person may have increased defense mechanisms surrounding their eating disorder and the lifestyle they have developed because of it, creating a sense of resistance toward changing. The maladaptive behaviors act as a coping mechanism for the person. Without the behaviors and

rituals the eating disorder has helped the person develop, someone with an eating disorder may feel as though they have no sense of control over stressful aspects of their life (Keski-Rahkonen and Tozzi, 2005).

The next stage of recovery is contemplation. In this stage, the person with an eating disorder has recognized that their eating disorder is negatively impacting them and may be considering recovery; however, they may be indecisive about changing at this stage. Similar to the pre-contemplation stage, the person is still practicing their negative habits as a coping mechanism. However, in the contemplation stage, the person is able to identify that the behaviors are negatively impacting them. While working toward change is a consideration, a person with an eating disorder may feel conflicted about pursuing it due to the framing of their eating disorder as a way to cope with stressful stimuli (Keski-Rahkonen and Tozzi, 2005).

The next stage is the determination stage. This is when the person with an eating disorder has decided to make a change and are preparing to take steps toward recovery. In this stage, the person with an eating disorder is making plans for change; however, the recovery process is more successful if this stage is not rushed by loved ones. The person with an eating disorder should be given the space to move at their own pace in order for them to take ownership and control over their own recovery process. In this stage, a person may begin to research and weigh their treatment options. They may go so far as to begin working with their primary physician, a psychologist, or a dietician. However, while the patient is in this stage, they may still be unsure about following through with recovery, resulting in very little, if any, change occurring at this time. This is also a stage where the patient may begin treatment, only to stop attending their appointments due to a hesitation to change (Keski-Rahkonen and Tozzi, 2005).

The next stage is the “action stage.” This is the stage where the preparations made in the previous stage are coming to fruition. Unlike in the previous phase, the person with an eating disorder possesses the motivation to actively take steps toward recovering from their eating disorder. A common step taken in this stage is participating in inpatient and outpatient treatment. Both inpatient and outpatient treatment consist of monitoring and improving physical, mental, and emotional health with the help of a treatment team. However, in the case of inpatient treatment, the patient stays in a treatment facility until their health is stable and they can manage their treatment in a less intensive setting, such as outpatient facilities. Outpatient treatment can consist of hour-long group or individual sessions or last for several hours at a time, in the case of intensive outpatient treatment. The steps taken in the action stage will be unique for each individual person (Keski-Rahkonen and Tozzi, 2005).

The next two stages are the maintenance stage and the relapse stage. During the maintenance stage, a person with an eating disorder is implementing and sustaining the skills they learned during their treatment in the action stage. They are continuing on their path to living a healthier lifestyle. In this stage, the maladaptive behaviors seen while the patient is struggling with an eating disorder may not be as present, if present at all. Instead the maladaptive behaviors are replaced with actions that positively contribute to their well-being and quality of life. New coping skills may be developed to deal with any possible triggers for old behaviors. These new coping skills will be a more positive replacement for past coping skills that led to maladaptive behaviors. If the person with an eating disorder can avoid or cope with their triggers, they may avoid relapse (Keski-Rahkonen and Tozzi, 2005).

The relapse stage is when a person with an eating disorder begins engaging in problem behaviors again for any number of reasons, including the occurrence of a traumatic event, lack of

positive coping skills, or lack of a positive support system. Relapse can result in feelings of failure and disappointment in oneself, which can feed into the recurrence of the problem behaviors. Relapse is most common within the first year after receiving treatment but can occur at any time during the recovery process. Treatment of a relapse is dependent on the severity of the returning symptoms. While relapses tend to be less severe than the initial eating disorder before treatment, there are instances where inpatient treatment may be revisited during the relapse stage, although this is not always the case. Generally speaking, outpatient treatment or self-monitoring will allow the person with an eating disorder to successfully achieve the maintenance stage again. However, relapse prevention is key in continuing recovery. Maintaining positive coping skills learned in treatment can be beneficial in preventing relapse. Self-monitoring, practicing self-care, and maintaining a positive support system of people who will help hold the person accountable for their continued recovery are other important ways of preventing relapse (Keski-Rahkonen and Tozzi, 2005).

The stages of recovery are not linear, nor do they have a definite time limit. A person with an eating disorder could potentially spend more time in one stage or another. One may also go from a relapse back to maintenance without having to go through each stage over again. One could also never reach the relapse stage and go into the transcendence stage. The transcendence stage is when a person no longer exhibits problem behaviors. At this stage, the problem behaviors are no longer present and the person with an eating disorder may consider themselves “fully recovered” (Keski-Rahkonen and Tozzi, 2005).

Upon discharge from treatment, a person recovering from an eating disorder must undergo a transition phase. In this transition phase, a person recovering from an eating disorder will often find that they have to readjust to life without the consistent support of a treatment

team. Often within inpatient settings, there is a set structure for each day in terms of individual therapy sessions, group therapy, psychiatric appointments, dietician appointments, and mealtimes. To go from inpatient treatment to being able to maintain recovery on their own can pose a challenge for a person beginning their recovery. Because of this, it is not uncommon for a person to continue with outpatient treatment as part of their transition phase before continuing to maintain their recovery on their own. With the additional step of outpatient treatment, the person in recovery has an opportunity to gradually acclimate to life without the structure and accountability of an inpatient facility (Davies and Bacon, 2017).

Another aspect of the transition phase is being discharged from outpatient treatment. When a person is discharged from outpatient treatment, they are then faced with the challenge of holding themselves accountable in their recovery process. This means sticking to a meal plan, practicing self-care and utilizing or developing new coping skills, navigating triggers to problem behaviors as they arise, maintaining an appropriate amount of physical activity, and seeking out support from loved ones and professionals as needed. While a person may have been previously discharged from inpatient or outpatient treatment, part of maintaining recovery and holding oneself accountable may mean seeking out further help from a professional such as a therapist, dietician, or psychiatrist. Having to seek extra support does not necessarily mean that the person is in the relapse stage. It could simply mean they are holding themselves accountable for their own recovery process and finding the resources needed to best maintain their recovery and prevent a relapse (Davies and Bacon, 2017).

As mentioned earlier, relapse can occur at any point during recovery, however, it is more likely to occur within the first year after receiving treatment. Relapse can happen during a period where the person recovering from an eating disorder feels like they are losing their control over

some aspect, or many aspects, of their life. One may feel as though they do not have the resources or positive coping skills necessary to continue to maintain their recovery, and have a “slip” or fall into a period of relapse. At this stage, a person in recovery may notice past problem behaviors surfacing once again, but they may need extra support to get back on track in their recovery journey. It is important to note that the person with an eating disorder is not “at fault” for relapsing during their recovery; however, this is a common belief for those experiencing a period of relapse. This is imperative for the social support system of a person with an eating disorder to understand in order to continue to effectively support a loved one experiencing relapse from an eating disorder (Davies and Bacon, 2017).

To reduce the likelihood of relapse, continuing the practice of therapeutic skills is beneficial. Each therapeutic modality has its own set of skills that can be translated into real-life situations, both as a supplement to therapy and as a coping mechanism after therapy has been terminated. For example, one may use the reframing technique utilized in solution-focused therapy, a technique in which the therapist and client work together to shift the perspective of a problem, situation, or a personality trait. In changing the perspective of a situation, the person’s behaviors or way of approaching the situation may change as well. For a person in continuing recovery, it may be helpful to take a thought, such as “if I eat, I will look fat” and change the perspective to “if I eat, I will be fueling my body and giving it the energy it needs to do the activities I love to do.” Not only is the reframed statement a more positive perspective on the same action, it also has the possibility to lead to a healthy behavior, such as eating a meal (Jessee, E. et al, 1982).

Narrative therapy is a form of intervention that utilizes storytelling as a way to separate the person from their mental illness or problem behavior. In many cases, the problem behavior

will be a character in the story that is separate from the protagonist, the person telling the story. The character of the problem behavior will often have a level of impact on the protagonist. A therapist using this technique might ask questions that frame the problem behavior in this light. For example, a therapist might ask a client with an eating disorder, “how has your eating disorder impacted your relationships with others?” prompting the client to think about their eating disorder as a problem rather than a personality trait. This technique can be helpful for those with eating disorders and can be utilized both in and outside of therapy. Similar to the reframing technique of solution-focused therapy, this intervention allows the person using it to view their presenting problem through a different lens (Center for Substance Abuse Treatment, 1999).

The form of therapy that is considered most effective in treating anorexia is Cognitive-Behavioral Therapy (Grohol, 2018). Cognitive-Behavioral Therapy, or CBT, focuses in on dysfunctional thoughts and beliefs that lead to maladaptive behaviors with the intention of changing them into thoughts and beliefs that are more beneficial to the person in recovery. Common practices in CBT include goal setting and rewarding oneself when a goal is reached. For someone in recovery from an eating disorder, an example of a goal they may set is to maintain the meal plan established with their dietitian. For each day they maintain this meal plan, they may reward themselves with something that is desirable to them, such as listening to music or buying themselves some new lotion. When the patient is able to choose their own rewards to work for, attaining the goal, in this case maintaining their meal plan, is more desirable (Grohol, 2018).

A form of therapy utilized in both inpatient and outpatient settings is creative arts therapy. Creative arts therapy is an umbrella term for several modes of psychotherapy that use art as a medium. This includes visual art therapy, music therapy, psychodrama therapy, and

dance/movement therapy. These forms of psychotherapy are known for their use of nonverbal processes, offering clients a means to process their inner thoughts and feelings on a body level. This provides the client with the space to explore emotions in a non-threatening way, as well as discover new ways to cope with stress. Creative arts therapy, or expressive therapies, allow an outlet for the somatic expression of psychological struggles. Through artistic means, these somatic experiences are expressed through the body, either with a paint brush, a musical instrument, or through movement. In working with visual art, one might draw or paint a representation of anger as it relates to their eating disorder. In music therapy, one may express sadness through connecting with a song. Psychodrama therapy could be used to role play an interaction with the eating disorder as if it was a separate entity from the self.

While each mode of therapy is effective in working with this population, dance/movement therapy is unique in that it provides the patient with access to a bodily felt experience through movement interventions. In this way, the patient is able to explore their emotional responses utilizing their body as their canvas. Dance/movement therapy is a body-based psychotherapy that connects the psychological processes of the mind to the physical processes of the body through movement. Because eating disorders impact patients on both a psychological and physical level, often by creating a disconnect of the perception of the body and the reality of the body, dance/movement therapy allows the patient to reclaim that connection to better match the perception and reality of the body. Much like eating disorders, dance/movement therapy actively engages the body to express psychological needs. However, unlike eating disorders, dance/movement therapy allows the client to express their needs in an adaptive way (American Dance Therapy Association, n.d.)

Dance/movement therapy is used as a treatment for eating disorders in many different ways. Kleinman (2014) takes into consideration key concepts related to eating disorders such as the need for feeling in control. For a person with an eating disorder, food may be used as a source of control. The person controls what they eat, how much they eat, and how they eat it. In dance/movement therapy, using a prop in a session may provide an outlet for that drive to feel “in control” in a more positive way. Props such as scarves, percussive instruments, and balloons act as a tangible tool to initially approach movement in a less intimidating way, because a person with an eating disorder may not feel safe or comfortable with the level of exposure involved in moving in front of others. A person with an eating disorder may also not have the means to access their own inner world right away. Having some props can make movement seem less scary due to the colors, sounds, movement qualities, or the nature of prop being used. The props can be manipulated and moved in different ways, which offers an alternative to manipulating food in different ways. Rather than exercising control around food and eating, a prop offers an alternate outlet of said control as they can be used and manipulated in a variety of different ways to suit the needs of the client. For example, a scarf is a soft and malleable prop that offers countless opportunities of exploration. One can use it to cover themselves, float it up towards the sky then watch it fall, or hold it in their hand as a flourish for their body movements. The concept of having something tangible, such as food, in which one can displace their sense of feeling out of control in other parts of life, is then translated into working with the scarf (Kleinman, 2014). In early recovery, wooden rhythm sticks may be used to explore emotions like anger or fear. Patients can explore what it feels like to make noise with the props by banging them together with their hands. To continue this movement experience, patients can create their

own rhythm with the sticks and use it to locomote around the room, expressing the emotion, like anger or fear, throughout their whole body.

Additionally, props are an effective way to separate the concept of “movement” from “exercise.” Because people with eating disorders sometimes engage in over-exercising, it is important to introduce dance/movement therapy as a mode of therapy utilizing movement rather than an opportunity for exercise. The movement in dance/movement therapy can range from locomoting in a highly active state to being an entirely internal experience, however the difference between movement and exercise is the intention behind it. In DMT, the intention behind the movement is utilized to enhance the therapeutic process, meaning the focus of the movement should be on working through an issue in a person’s life. Moving with a prop can act as a reminder that the intention of the movement is the therapeutic process (Kleinman, 2014).

Another technique used in dance/movement therapy to treat people with eating disorders is mindfulness and meditation. During mindfulness practices, a person may focus on their breath, an image, a bodily sensation, a voice, or sounds as a means to relax and tune in with their body. In early stages of recovery, mindfulness may be difficult to access due to the complexities of the psychological symptoms associated with eating disorders. In this phase of recovery, the patient’s goals of mindfulness may be to pay attention to and tolerate being with their own body. The use of imagery may provoke different memories and emotions to come to the surface that can be explored through movement. This helps bring forward emotions or experiences that may not be addressed in other parts of life. For a person with an eating disorder, exploring these experiences in the safety of a dance/movement therapy session can help them understand their emotions and how it impacts their relationship with their eating disorder. From here, the therapist may help

them work through their emotions and help lessen the psychological impact they have on the person with an eating disorder (Davies and Bacon, 2017).

Padrao and Coimbra (2011) highlight dance/movement therapy concepts such as exploring the connection and boundaries between the self and others, relearning to listen to bodily cues such as hunger, and exploring control through increasing bodily awareness. When a person increases awareness of their body and how it reacts to different stimuli, this can act as an important stepping stone in learning healthier ways to react to these same stimuli. Through mindfulness and the body-based practice of dance/movement therapy, this awareness can be increased, leading to a better understanding of one's own body and mind, including how one perceives their own body and bodily cues (Padrao and Coimbra, 2011).

Existing research highlights the value of using dance/movement therapy to treat eating disorders; however, the research on its use with people in recovery from an eating disorder appears to be lacking. For example, current research does not cover what later stages of recovery, the maintenance and relapse stages, might look like for someone recovering from an eating disorder. How does one transfer skills learned in earlier stages of recovery to maintain their progress and avoid relapse? Current research often does not address the challenges of being in late stages of recovery, such as having to transfer skills learned in the structured environment provided by treatment facilities to a less-structured environment one might have in life outside of treatment. There is also a lack of research detailing the developmental processes of recovery from early stages of recovery to later stages of recovery. How do they differ and how does one alter their coping skills to adapt to their recovery development?

In continuing recovery, people with eating disorders are faced with the challenge of maintaining their progress post-treatment using skills that they have learned and adapted during

their treatment process. The need to adapt to returning to their old environments with newly acquired skills that have not yet been practiced in that environment is often one of the biggest challenges for people in recovery from an eating disorder, particularly if their social support is lacking. With a strong support network of friends, family members, and other positive influences holding them accountable, this transition may feel more manageable (Center for Substance Abuse Treatment, 1999).

Maintaining therapeutic tools after terminating treatment not only provides a sense of security in having a set of positive coping skills, but it also acts as a method of transitioning out of treatment and into everyday life scenarios. Because this transition phase can be a potential point of relapse for those with eating disorders, it is important that they feel prepared to continue moving forward in recovery without the help of their treatment team. Educating the patient on interventions they can provide for themselves when they are tempted to engage in past problem behaviors will empower them to take control over their own recovery (Center for Substance Abuse Treatment, 1999).

Current research on people in recovery from eating disorders focuses around practices of different forms of talk therapy such as cognitive-behavioral therapy, humanistic therapy, dialectic-behavioral therapy, and solution-based therapy. However, there has been minimal research done on the use of dance/movement therapy and dance/movement therapy concepts with people in continuing recovery from eating disorders.

Research has shown how aspects of dance/movement therapy, such as mindfulness, focus on the use of breath, attention to rhythm, and use of imagery can be beneficial for a person in treatment from an eating disorder, however, it does not highlight how similar practices can be taken out of the context of treatment and into the real world for those who are in continuing

recovery. The continuation of using therapeutic techniques post-treatment not only allows the person with an eating disorder to maintain their feeling of control over their eating disorder, but it also decreases the likelihood of relapse.

Discussion

Different phases of recovery require different levels of attention to the recovery process. Early recovery is the period of time when a person begins their recovery, but is not yet stable enough to maintain it on their own without some form of structure. This period of recovery begins in the “action stage” of the aforementioned “Stages of Recovery” model (Keski-Rahkonen and Tozzi, 2005) and goes into the “maintenance stage.” After about a year of post-treatment, a person may be considered to be in late recovery if they are able to maintain their recovery without much intervention from their treatment team. They may continue working toward maintaining recovery without the structures they followed during treatment. For example, if a person with an eating disorder followed a strict meal plan while in treatment, they may continue to follow it after treatment, but gradually begin to adjust the meal plan in a way that fits their current lifestyle. A person in early recovery would still be following the meal plan while a person in late recovery would be familiar enough with listening to their body’s hunger cues to know when it is time to eat.

One of the staples of eating disorder early stage recovery is reestablishing a relationship with the body. Many people with eating disorders will struggle with negative body image, experience a disconnect with the body, or block out its hunger or satiety cues. Much of the recovery process is working to heal this disconnect. In this case, a disconnection between the mind and the body can be described as an inhibited ability to make sense of bodily sensations such as hunger, satiety, or anxiety. This can result in a lack of awareness of these sensations and

a decreased ability to know how to handle them. A person with an eating disorder will grow so accustomed to ignoring their body's signals that they eventually may not notice them at all. In early stages of recovery, the focus will be around reconnecting with the body to notice and respond to these bodily cues. However, in later stages of recovery, one will have developed a sense of bodily awareness and the work becomes more centered around acknowledging bodily cues and continuing to nourish the body as needed as to make the return to normalcy in regard to eating habits.

Dance/movement therapy techniques such as mindful sequential breathing and body scanning, self-soothing rhythms and action rhythms, role-play as a strong entity that one can identify with, and nature imagery are all commonly used with people in early stages of recovery, specifically during treatment. However, these same aspects of dance/movement therapy can be utilized by individuals in long-term recovery from eating disorders when adapted to fit their developmental stage of recovery.

Rhythm and breath support are some of the most accessible dance/movement therapy concepts that are transferable in the real world throughout recovery due to their universality. Living beings are connected by the rhythm of their heartbeat as well as their need to breathe. Because of this universality, rhythm and breath support have a grounding effect. The concept of "grounding" relates to one's ability to focus, maintain stillness, and to increase one's capacity to give in to supports. Grounding reflects a sense of being with oneself and maintaining a sense of focus on relaxation.

Connecting with one's breath by taking some deep breaths not only regulates shallow breathing, but it also can help a person with an eating disorder calm themselves and think more clearly due to increased oxygen flow to the brain. Practicing breathing exercises in early

recovery lays the foundation for more advanced practices such as meditation and mindfulness in later stages of recovery. In early recovery, breathing practices may be shorter lived and may be more centered around simply being able to be with oneself in a quiet space. In later recovery, a more meditative state may be achieved and the ability to remain mindful of one's own thoughts and feelings will be sustained for longer periods of time. In later stages of recovery, a dance/movement therapy intervention that could be utilized is a full-body relaxation. To do this, a client would lie down on the floor or on a yoga mat as the therapist guides them through this experience. The therapist would begin by leading the client in taking a few slow, deep breaths. Gradually, the client would increase their focus on visualizing the inhale and the exhale. The therapist would guide the client in visualizing their breath reaching each body part from their toes up to their head with each inhale. With each exhale, the breath would slowly fade away like a wave leaving the shore. This would continue until breath has been sent to each body part with the intention being to relax the body. This practice is useful for those in late stage recovery in that it helps them to more effectively deal with anxiety and increases their frustration tolerance.

Rhythm is used in dance/movement therapy to promote organization, provide structure, and connect with oneself and others. From one's early days in the womb to one's last breath, humans are exposed to the most central rhythm of life, the heartbeat, first from their mother and then their own. Rhythms act as building blocks in human development (Kestenberg-Amighi et al, 2018).

Kestenberg (2018) identifies two types of rhythms, known as tension flow rhythms: indulging and fighting. Indulging rhythms are associated with a sense of relaxation and soothing, such as the oral sucking rhythm which originates in the mouth at infancy when a baby is feeding. This tension flow rhythm is used to nurture and self-soothe, while fighting rhythms are more

closely associated with separation and tension. An example of a fighting rhythm is the spurting/ramming rhythm, which might look like sudden kicks and punches into the air, used to establish a sense of self. Each serves its own purpose in development in relation to biological needs and drives such as receiving nourishment and releasing excrement. Each rhythm is also associated with a psychological task such as self-soothing, boundary setting, and differentiation of the needs of the self from the needs of another person (Kestenberg-Amighi et al, 2018).

Problems may arise when there is a lack or an overabundance of one of the rhythms. A lack of a rhythm means that that developmental rhythm is not present in a person's movement patterns, which can indicate a lack of an ability to provide necessary self-care skills for oneself. To have an overabundance of a rhythm is to exhibit too much of a particular movement pattern, resulting in a crossing of boundaries or engaging in behaviors that are harmful to the person exhibiting an overabundance of a rhythm. A dance/movement therapist may recognize an overabundance or lack of a tension flow rhythm in a person with an eating disorder and implement an exploration of tension flow rhythms as an intervention. For example, the swaying tension flow rhythm can be used to self-soothe and care for oneself. For a person with an eating disorder, moving their core gently from side to side in the swaying rhythm may be an effective way to practice relaxation or self-care, as those with eating disorders tend to favor the destructive behaviors associated with the eating disorder over their own self-care due to the familiarity of the behaviors and the lack of other coping skills (Kestenberg-Amighi et al, 2018).

Exploring rhythm either through the use of music or through movement is an effective way to self-soothe in times of distress. While listening and dancing to music can stimulate the mind and body connection, one may also work with rhythm through tapping on the body using their hands or fingertips. Patting or tapping the body from the head down to the feet or vice versa

helps to soothe the person experiencing it, organize the brain due to the sequential process of tapping each body part in a particular order, and can familiarize a person with the body's many pressure points. In early stages of recovery, this will give the person an increased understanding of what helps them to relax in their own body when faced with a triggering situation, which will set them up for success in later stages of recovery. This practice also facilitates a grounding feeling and aids in focusing on the present moment. Because of this, it is beneficial throughout eating disorder recovery in that it allows the person time to focus on the sensations of their hands on their body rather than continue to perseverate on the triggering situation. This act of focusing the mind using tapping hand movements on the body aids in relaxing the person, as well as giving them a moment to think more clearly without the influence of anxiety perpetuating maladaptive behaviors. The level of ability to focus and maintain mindful awareness on bodily sensations will increase as one continues into later stages of recovery.

While the Kestenberg Movement Profile rhythms are appropriate for those in early stages of recovery, people in later stages of recovery have an increased capacity to expand their movement repertoire. Their movement becomes more of a full-body experience as they grow more comfortable in their bodies and their body image improves. They may be more comfortable with taking up more space and expanding their movements to reflect this by utilizing more of the physical space in the therapeutic setting. The intention of their movement also changes as the focus of their recovery changes. Rather than focusing on self-soothing rhythms, their movements will become more action-oriented. Action-oriented movements will serve to accomplish a specific goal such as connecting with others, regulating old movement patterns that hindered their recovery such as engaging in fast-paced over-exercising, and setting boundaries.

One way to explore boundaries through dance/movement therapy is to utilize elements of Laban Movement Analysis. In dance/movement therapy, Laban Movement Analysis is used to aid in the observation, description, and notation of a client's movement to provide insight on how to best treat them. Laban uses effort qualities to describe movement in the parameters of space, weight, time, and shape. For example, in working with a person with an eating disorder, a therapist might consider the movement qualities of Strong Weight Effort and Direct Space Effort. When used together, Strong Weight Effort, or having a strong connection with the pull of gravity, and Direct Space Effort, moving through space without redirecting focus to another object, can be an effective way of embodying a powerful force. For example, stomping feet or punching the air motivates the body to assert this powerful energy. This assertiveness can be carried over into boundary setting. To explore assertiveness and boundary setting in a therapy session, one may explore strong movements such as "putting a foot down" by stomping their foot into the floor with power and force. In this case, the therapist and client would consider areas where more boundaries are necessary, such as in overcoming obsessive thoughts about food, shutting down urges to engage in maladaptive behaviors, or in communicating one's needs with loved ones. They would then practice "putting a foot down" or putting a hand up as if saying "stop" to set the boundary for themselves. Using verbalizations such as "No!" or "Stop!" may also be beneficial in experiencing boundary setting in the body in a safe environment such as the therapeutic space before utilizing these skills in real-life scenarios. Setting clear boundaries in an assertive manner about the person in recovery's needs from their loved ones not only provides this information to the person who needs to hear it, but also empowers the person in recovery to maintain their boundaries. This skill is more accessible to those in later stages of recovery, as opposed to earlier stages of recovery, as earlier stages of recovery have a stronger focus on

surviving rather than thriving. While in earlier stages, it would be more appropriate to practice skills such as developing and sticking to a meal plan and utilizing the treatment team for support; those in later stages of recovery have the capacity to expand their skill set to support their new phase of recovery. In later stages of recovery, it is expected that people will further adapt to life post-treatment by incorporating aspects of their life before their treatment. This will include returning to old routines, working environments, and the people in their lives. While there is less support from a treatment team in later stages of recovery, it is imperative that a person with an eating disorder be able to rely more on themselves in maintaining their recovery. Creating and maintaining boundaries is important because they are a means of supporting healthy habits. A person in later stages of recovery has learned how to maintain their recovery and being able to set clear boundaries supports them in doing so (Barteneiff, 1980).

In maintaining long-term recovery, the people one surrounds themselves with are critical. While in treatment for an eating disorder, it is common to discuss what forms of support the person has when they leave treatment. This includes members of the treatment team as well as family, friends, teachers, teammates, co-workers, and members of the clergy. A support network is comprised of people who are willing to hold a person in recovery accountable for their progress, provide assistance during difficult periods, and be a positive influence in the life of the person in recovery. Having a supportive social network can reduce the feeling of isolation often associated with eating disorders and can act as a source of accountability throughout the recovery process.

One of the challenges that may arise as recovery progresses is when a friend, family member, or other loved one is not supportive of the recovery process. Maybe the loved one makes offhanded comments about the person in recovery's body, encourages them to eat more or

less than they are comfortable with, is dismissive when they ask for help, or is otherwise disruptive to the recovery process. When this happens, the person in recovery has to consider how they are going to navigate this challenge. In early recovery, one may have access to their therapist to explore boundary setting. Establishing boundaries with negative influences empowers the person in recovery to continue working toward more positive lifestyle changes without the added barriers created by a person who does not have their best interest at heart.

Role-playing is a technique used in dance/movement therapy that allows the client to create a character that possesses qualities that are desirable for the person taking on the role of that character. One might take on attributes of a person they admire or an animal that inspires them. The intention is to empower oneself by embodying these attributes in their own body in a non-threatening way. In early recovery, a person with an eating disorder may feel like they are lacking in a trait such as confidence, courage, resilience, or strength. Embodying a person, animal, or fictional character who has these qualities provides them with an opportunity to feel that quality in their own body when they feel like they need some extra motivation to continue with their recovery.

In later stages of recovery, rather than embodying a character or person who resembles positive traits, one can create a body movement or sequence of movements that they can come back to when they need a reminder that they are stronger than their eating disorder. The movement can be repeated as many times as is necessary for the person to feel confident that they can overcome the urge to engage in the problem behavior. Exploring this concept through movement may be more abstract than embodying a tangible character, however, the abstract may be more accessible, as well as more time efficient, for someone in later stages of recovery as they have more experience with coping skills and have a higher level of self-awareness required to

adapt a coping skill to their needs. In dance/movement therapy practice, a person in recovery from an eating disorder may find it helpful to have a strong character or force of nature that they embody to confront their eating disorder. A common term within the eating disorder recovery community is “recovery warrior” or “NEDA Warrior” popularized by the National Eating Disorder Association. The idea behind this term is that people in recovery from eating disorders are fighting a “battle” with their disorder (National Eating Disorder Association, n.d.). The idea of a warrior is one that can be used for role-play when a person in recovery feels compelled to engage in their old maladaptive behaviors.

Imagery is used in eating disorder treatment as a means of visualizing something familiar that symbolizes something greater than meets the eye. Burgunder (2019) uses the image of a weed to illustrate the author’s experience with an eating disorder. The eating disorder begins as a seed that soon becomes a weed as the author continues to “garden” it and continue with the disordered behaviors. As she describes her recovery process, she explains that it started by ripping the weed out and planting a new seed to represent her recovery process. The seed of recovery will eventually bloom and continue to grow as she continues her own recovery. Having an image that a person in continuing recovery can connect to may be a strong coping skill for some that prevents them from engaging in problem behaviors. Plants and trees are common images related to growth. Imagery of toes in the sand and waves on a beach are common for relaxation. Any symbol or scene that resonates with a person in continuing recovery can be used to ground, to relax, or to inspire. (Burgunder, 2019).

In later stages of recovery, the capacity for self-awareness and to be with oneself increases due to longevity of practicing these skills as well as a strengthening of the ego. The focus of recovery also shifts from being more survival-focused during early stages of recovery to

being more driven by quality of life and a return to normalcy. This means that rather than working toward recovery to survive, a person in later stages of recovery will place more of an emphasis on recovering to thrive. Nature is often a feature in imagery practices due to the familiarity many people have with the different elements of nature, such as water, trees, mountains, and wind. Visualizing nature also provides the freedom to contribute one's own experience with nature to create a unique experience for themselves. One example of nature imagery that could be used for people in long-term recovery from eating disorders is to visualize wind blowing their triggers or harmful thoughts away. At their own pace, a person in recovery can imagine a gentle breeze, a windstorm, or a tornado blowing their triggers away. This experience could be done completely internally or could be explored through movement with the person becoming the wind and pushing their anxiety away. While this exploration could be introduced to people in short-term recovery, it may not be as effective without supplementary interventions due to the use of mindfulness practices, which, as mentioned before, may not be as accessible to those just beginning the recovery process. This is due to the continuing developmental processes involved in the recovery process.

Long-term recovery from eating disorders has its own challenges not fully addressed in the literature of dance/movement therapy. While the focus of dance/movement therapy has been primarily on early stages of recovery, many of the practices must be suitably adapted for use with those in later stages of recovery. Long-term eating disorder recovery focuses on the process of a person continuing to separate themselves from their eating disorder. By the time one enters later stages of recovery, they will have gained the skills and the self-awareness necessary to successfully maintain their recovery. The maintenance stage sees a person with an eating disorder being able to regain a sense of normalcy in their everyday life. Dance/movement

therapy offers a safe therapeutic environment for supporting the transition from the focus on adapting healthier habits to the focus of incorporating learned coping skills and healthy habits into the person's existing environment.

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