

Molloy University

DigitalCommons@Molloy

Faculty Works: Clinical Mental Health
Counseling

Clinical Mental Health Counseling

2-11-2015

Building Response Flexibility in Clients with Eating Disorders: Improvisation and Embodying Addiction

Laura L. Wood Ph.D., LMHC, RDT_BCT
Molloy College, lwood@molloy.edu

Follow this and additional works at: https://digitalcommons.molloy.edu/cmhc_fac



Part of the [Counseling Psychology Commons](#), and the [Counselor Education Commons](#)

[DigitalCommons@Molloy Feedback](#)

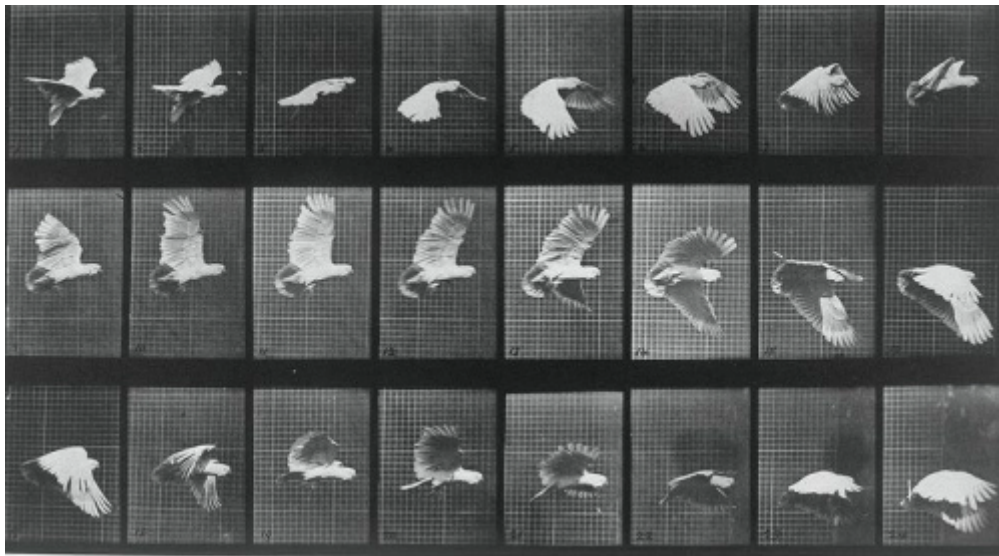
Recommended Citation

Wood, Laura L. Ph.D., LMHC, RDT_BCT, "Building Response Flexibility in Clients with Eating Disorders: Improvisation and Embodying Addiction" (2015). *Faculty Works: Clinical Mental Health Counseling*. 2. https://digitalcommons.molloy.edu/cmhc_fac/2

This Article is brought to you for free and open access by the Clinical Mental Health Counseling at DigitalCommons@Molloy. It has been accepted for inclusion in Faculty Works: Clinical Mental Health Counseling by an authorized administrator of DigitalCommons@Molloy. For more information, please contact tochter@molloy.edu, thasin@molloy.edu.

Dramascope

Building Response Flexibility in Clients With Eating Disorders: Improvisation and Embodying Addiction



By **Laura L. Wood, MA, RDT-BCT, LPC, CCLS**

Currently, statistics show that individuals with eating disorders have a higher mortality rate than those suffering from any other mental illness (Smink, van Hoken & Hoek, 2012). No single type of treatment is universally successful; rather each eating disorder type (Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder) responds to its own unique course of treatment. Even though there has been significant growth over the last twenty-five years in treatment approaches for different types of eating disorders, there is still a significant gap in what we know to be effective (Fairburn & Harrison, 2003). Unfortunately, public interest in eating disorders and common misunderstandings about the disorder far outweigh the research being conducted in eating disorder treatment. In fact, most research is housed in psychiatry department medical schools (Wilson, Grilo & Vitousek, 2007). In 2007, Wilson, Grilo, and Vitousek presented a call to researchers (other than medical doctors) to increase the research for eating disorders, declaring that we as psychologists and counselors are “well positioned to make important contributions to the study of eating disorders...including exploring psychobiological mechanisms that cause and maintain eating disorders, and identify the mechanisms (mediators) of therapeutic change” (p. 212). Answering this call, my work and current research in progress (and this blog submission!) are focused on using drama therapy to help clients with eating disorders to build response flexibility.

It is well known in the field that the cause of an eating disorder is complex. Both genetic predisposition and environmental factors contribute to the use of an eating disorder as a maladaptive coping mechanism (Fairburn, 2008). The different contributing environmental factors can be grouped into the

following three broad categories: trauma and abuse, anxiety, and developmental/family of origin issues. Clients with eating disorders often have a make-up of factors from one, two, or all three of these categories. While there are different treatment tracks for eating disorders associated with each category of factors, there are also areas of overlap. All clients with eating disorders (with whatever combination of trauma, anxiety or developmental/family of origin problems), for example, suffer from issues of response flexibility. "Response flexibility enables us to pause before responding as we put a temporal and mental space between stimulus and response and between impulse and action" (Siegel, 2012 p. 33-2). Clients with eating disorders, rather than having healthy response flexibility, suffer from extremes of rigidity and chaos (Cassin and Von Ranson, 2005). With rigidity (most common in clients with Anorexia Nervosa), thought, emotional, and behavioral repetition become the primary way of coping and identifying, rather than a sense of spontaneity, creativity, playfulness, and presence. Extreme chaos is characterized by the intrusion of overwhelming and unpredictable thoughts, emotions and behaviors (most often seen in clients with Bulimia and Binge Eating Disorder) (Siegel, 2010; Claes, Vandereycken, and Vertommen, 2002).

To encourage movement away from rigidity and chaos and towards healthy response flexibility, Siegel (2012) suggests we help clients increase their window of tolerance: the "span of tolerable levels of arousal in which internal or external stimuli can be processed in a flexible and adaptable manner" (p. 85).

Coming to understand the protective functions of an eating disorder is one of the first steps in formulating a treatment approach. This process is often very frightening for clients, triggering their rigid or chaotic response strategies to deal with the uncomfortable feelings that arise when exploring this material. For example, if asked to write, as a means of exploration, about the function of their eating disorder, rigid clients often become entrenched in writing and re-writing. The focus shifts from developing insight about their eating disorder through spontaneity, connection, and discovery, to writing a "perfect paper" that has outstanding grammar and punctuation. Conversely, chaotic clients use the writing as an opportunity to "purge" their feelings. They may write fifteen pages of repetitive and unorganized thoughts that perpetuate their chaotic way of coping, leaving them feeling more dysregulated and confused. I have found that in the *early* stages of treating clients' eating disorders, writing is minimally useful. In many ways, this is also true for other traditional verbal methods within the group therapy process. Rigid clients sit, and think, and find a way to give the "perfect" controlled answer that won't open them up to vulnerability. Meanwhile, chaotic clients ramble on, often getting so lost in the telling of their experience that other group members feel equally lost, and they are left feeling alone, isolated, and misunderstood. When these patterns are mirrored for clients with eating disorders, often their shame and self-hate is so rigid/chaotic they can't tolerate the feedback. Trapped again, they turn to their soothing friend, the eating disorder, with whom they continue to play out their rigid (restriction) and chaotic (binging and purging) patterns.

Therefore, helping clients to discover the functions of their eating disorder in a way that doesn't perpetuate their rigid and chaotic coping styles is essential. This is why in the early stages of eating disorder treatment I begin with two different types of groups that work in conjunction with one another to begin to increase clients' windows of tolerance in order to help build response flexibility:

- 1) A Drama Therapy group in which we explore the role of the eating disorder through the lens of the Internal Family Systems (IFS) Model.
- 2) A modified Developmental Transformations (DvT) Group that allows clients to start learning to play with their rigidity and chaos (which also helps minimize the triggering of their shame and self-hate).



https://thedramascope.files.wordpress.com/2015/02/img_3197.jpg

Wood lecturing at a recent conference in Alabama helping clinicians to experience drama therapy and it's benefits for eating disorder clients.

In the Drama Therapy group, clients are given the opportunity to spontaneously play their eating disorder. This begins with clients embodying – sculpting, without words – what their eating disorder is trying to communicate. First, we look at each sculpt objectively: “The client playing their eating disorder is standing on the chair, giving the middle finger,” “The client is holding the chair up in front of them, hiding their body,” “The client is sitting up straight at the edge of the chair, with their hands folded and a big smile,” etc. We then look at the clients’ sculpts subjectively: “Maybe the eating disorder is giving the middle finger because it communicates the client’s anger?” “Maybe the eating disorder has helped this person to hide in their life?” “The eating disorder seems to put on a perfect mask for the world to see.” The client can then de-role and have someone else take on the role of their eating disorder while they have the opportunity to look at their sculpt objectively and subjectively. This slowing down process, and the opportunity to move between the eating disorder being “me-and-not-me” (Landy, 1994) seems to lay the groundwork for creating windows of tolerance to generate different response flexibility. For some clients sculpting is enough, others move into doing an improvised monologue, speaking as the eating disorder. To take the work one step further, the group can play the *compassion-curiosity panel*, asking the eating disorder questions in order to better understand its functions.

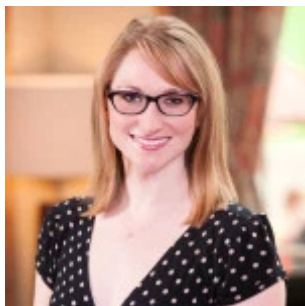
The concept of approaching an eating disorder from a place of compassion and curiosity comes from Richard Schwartz’s model of Internal Family Systems, which purports that the mind is an “ecology of relatively discrete sub-minds, each one intrinsically valuable and seeking a positive role within the internal system” (Johnson & Schwartz, 2005, p. 75). Each part is unique, and yet, they take on three common roles: Managers, Exiles, and Firefighters. The Exiles develop “when a person has been humiliated, frightened, or shamed in the past” and carries “the emotions, memories, and sensations from those experiences” (Johnson and Schwartz, 2005 p. 76). The Managers work to protect these wounded parts of ourselves and keep us functioning on a day-to-day basis, holding the painful experiences at bay. When an experience triggers the Exiles, and the Managers’ protection isn’t working, the Firefighters come in to “extinguish the inner flames of feeling as quickly as possible. (...) Firefighters tend to be highly impulsive and seek stimulation that will override or dissociate the person from the Exiles’ feelings. Binging on drugs, food, alcohol, sex, or work are common Firefighter activities”

(Johnson & Schwartz 2005, p.76). At the heart of the model is the concept of Self. Each person is born with a Self, and one is in Self when embodying curiosity, compassion, clarity, courage, creativity, connection, and calmness. In Internal Family Systems, people learn to create a Self to Parts relationship. "When the Self is in charge, it is possible to bring healing to the Exiles and to create harmony in the internal system. Health is defined as the Self having a positive leadership role with all the parts, valuing the intent of each, and creating teamwork among them" (Johnson & Schwartz, 2005, p. 77).

When eating disorders are approached from a place of Schwartz's Self, clients can depart from rigid and chaotic responses and move towards a place of curiosity, a desire to better understand the way their eating disorders have helped them to survive. When this window of tolerance is created and the clients begin to practice new ways of understanding themselves, we often see a shift in their motivation. They become more driven to continue to unfold their underlying narratives and begin to practice new ways of engaging with themselves and others.

Clients also participate in a weekly Developmental Transformations (DvT) group that primarily uses *the cauldron exercise*, which stems from a classic improvisation game from Viola Spolin (1963). Two people share the space and engage in an improvised scene, and at any point a third player can tag out one of the actors and insert themselves into the scene. In our version, the same structure of the game applies, but all of the principles of DvT are also involved. As the play progresses, more people can enter and exit through the portal. I believe that Johnson's (2013) Recursive Interpersonal Process in DvT (noticing, feeling, animating and expressing) are all steps that foster clients' movement towards response flexibility in the present moment. As I have found with clients with eating disorders, this first level of engagement in improvisation and DvT allows one to "lower fear of the instability of Being, rather than lowering the instability of Being ... lowering one's own fear of instability involves learning how to accept risk and learning to maintain one's balance amidst uncertain circumstances" (Johnson, 2013 p. 32). In essence, it seems the DvT playspace with more structure (in early phases of treatment) helps to increase clients' windows of tolerance and opportunities to play with choices other than rigid or chaotic responses. DvT also offers an opportunity to overtly play out rigid and chaotic responses in which the therapist can offer playful mirroring that doesn't trigger shame and self-hate. Even if they are triggered, the discrepancy between reality and playful encounter allows the shame and self-hate be played with in a way that increases tolerance. The combination of the IFS drama therapy groups and DvT groups helps create an excellent fundamental foundation that therapists can use to scaffold into the next phase of eating disorder treatment.

As stated earlier, there is an important call for those who work with eating disorders and addictions not only to discover creative methods of treating this challenging (but deeply rewarding!) population, but also to continue to strive for research in this area moving forward. I hope you will take time to check out an article I wrote recently with my co-worker, Christine Schneider, on [the use of Interpersonal Neurobiology and drama therapy](http://www.ingentaconnect.com/content/intellect/dtr/2015/00000001/00000001/art00005?crawler=true) (<http://www.ingentaconnect.com/content/intellect/dtr/2015/00000001/00000001/art00005?crawler=true>).



Laura Wood, MA, RDT-BCT, LPC, CCLS graduated with her MA in Drama Therapy from New York University and is currently a fifth year doctoral student at the University of Missouri-Saint Louis. She is the Lead Therapist at Castlewood Treatment Center for Eating disorders, where she has worked for the past six years. She lectures nationally and is delighted to be on the board of the NADTA as the Central Region Representative.

References:

- Cassin, S. & Von Ranson, K.M. (2005). 'Personality and eating disorders: A decade in review' *Clinical Psychology Review* vol. 25, pp. 895-916.
- Claes, L, Vandereycken, W, & Vertommen, H. (2002). 'Impulsive and compulsive traits in eating disordered patients compared with controls,' *Personality and Individual Differences*, vol. 32, pp.707-714.
- Fairburn, C.G. & Harrison P.J. (2003). 'Eating disorder' *The Lancet*, vol 361, pp.407-416.
- Fairburn, C.G. (2005). 'Evidence-based treatment of anorexia nervosa' *International Journal of Eating Disorders*, vol. 37(Suppl.), S26-S30.
- Johnson, D.R. (2013). *Developmental transformations: text for practitioners*. Vol. 2.
- Johnson, L. M., & Schwartz, R.C. (2005). Internal family systems work with children and families. In C.E., Bailey (Ed.), *Children in therapy: Using the family as a resource* (pp.73-111). New York, NY: WW Norton & Co.
- Landy, R.J. (1996). *Essays in drama therapy: The double life*. Jessica Kingsley Publishers, London.
- Landy, R.J. (1994). *Drama therapy: Concepts, theories and practices*. Charles C. Thomas, Springfield, IL.
- Landy, R.J. (1993). *Persona and performance: The meaning of role in drama therapy and everyday life*. Guilford Press, New York.
- Siegel, D.J. (2012). *Pocket Guide to Interpersonal Neurobiology: an integrative handbook of the mind*. New York. Norton & Company.
- Siegel, D. J (2012). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*. Random House, Inc.
- Smink, R.E, van Hoken, D. & Hoek, H.W. (2012). Epidemiology of eating disorders: incidence, prevalence and mortality rates. *Current psychiatry reports*. Vol. 15-4 pp. 406-414.
- Spolin, V. (1963) *Improvisation for the theater*. Chicago: Northwestern University Press.
- Wilson, G.T., Grilo, C.M. & Vitousek, K.M. (2007). 'Psychological treatment of eating disorders,' *American Psychologist*, Vol. 62-3, pp 199-216.



6 Comments



Great job describing ways to help clients get out of being in their rigid/chaotic places!

posted February 11, 2015 at 8:36 PM by drtonyamcfarland

Reply



Thanks so much Laura for this wonderful article! I have been using DT and DMT with this population in groups in psychiatric settings and now in private practice for many years and have written also about it. We are a small group so it is great to share.

Many blessings, Tannis

posted February 16, 2015 at 8:31 PM by Tannis Hugill

Reply



beautifully written Laura! your work is so compelling, I could not put it down! thank you for all you do.

posted February 17, 2015 at 12:04 AM by Karimah

Reply



Thank you so much for the kind words, Tonya, Tannis and Karimah!

posted February 28, 2015 at 2:53 PM by centralregiondramatherapy

Reply



Laura ... thank you for sharing your work in this most descriptive and evocative way. As a dance/movement therapist, I found myself resonating with much of what you said. I appreciated hearing how you creatively approach your work with this potentially challenging, yet rewarding, population. I am feeling inspired.

posted March 19, 2015 at 12:30 AM by Jody Wager

Reply

Pingback: [Year in Review | Dramascope](#)



FEBRUARY 11, 2015

THEDRAMASCOPE

DRAMA THERAPY, DVT, PLAYSPLACE, TRAUMA-INFORMED DRAMA THERAPY

[Blog at WordPress.com.](#)