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Playing the Roles of the Eating Disorder: Suggestions for the Use of Drama Therapy in Adolescent Residential Eating Disorder Treatment

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Drama Therapy

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Abstract

Adolescents with eating disorders are faced with a variety of medical and psychological complications. This literature review examines these complications and the treatments available to adolescents with eating disorders, as well as factors influencing treatment resistance and dropout, specifically at the residential level of care. Additionally, the use of drama therapy as a treatment option for adolescents with eating disorders is explored. The use of role theory and role based work is proposed as a way of tackling treatment resistance in adolescents. Through role-based work, a client is given the opportunity to explore the functional aspects they attribute to their eating disorder, including but not limited to the roles of identity, control, and guardian. Further research recommendations include creating manualized versions of drama therapy for the treatment of eating disorders, additional outcome studies about residential eating disorder treatment, and an exploration of role expansions before and after treatment.

Keywords: drama therapy, role theory, eating disorders, adolescents, residential treatment

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Introduction

Eating disorders, such as anorexia nervosa, bulimia nervosa, binge eating disorder, and

otherwise specified feeding and eating disorder, are complex psychological disorders that require

a multi-theoretical approach to treatment (Peckmezian & Paxton, 2020; Twohig, et. al., 2015).

The current literature suggests that eating disorder psychopathology is maintained by positive

psychological meanings held by clients (Serpell, et. al., 1999; Serpell & Treasure, 2002)

resulting in higher treatment dropout rates (Abbate-Dage, et. al., 2013) and greater treatment

resistance (Stockford, et. al., 2018). Clients have identified their eating disorders as playing the

role of self (Williams, et. al., 2016), the role of control (Froreich, et. al., 2016), and the role of

guardian (Serpell, et. al., 1999; Serpell & Treasure, 2002) as functional aspects of the disorder.

Current treatment approaches for adolescents with eating disorders exist at five levels of

care: outpatient, intensive outpatient, partial-hospitalization, residential, and inpatient (APA,

2010; Peckmezian & Paxton, 2020). The residential level of care is a 24- hour level of care for

clients who do not need medical intervention but do require more intense treatment for the

psychological effects of their eating disorder (Twohig, et. al., 2015). These residential centers

typically offer family-based therapy, cognitive behavioral therapy, dialectical behavior therapy,

pharmacological treatments, and expressive arts therapies as form of treatment (Clark, et. al.,

2015; Peckmezian & Paxton, 2020; Twohig, et. al., 2015; Williams, et .al., 2020; Wood, 2015).

The expressive therapies are frequently used in residential setting (Twohig, et. al., 2015)

and researchers have provided qualitative evidence for the effectiveness of creative arts in the

treatment of eating disorders (Frisch, et. al., 2006; Heiderscheit, 2015). Drama therapy, which

uses theater processes to achieve therapeutic goals (NADTA, 2021), provides an embodied experience of internal mechanism that have shown promise in improving treatment outcomes (Pelliciari, et. al., 2010; Wood, 2015; Wood & Schnieder, 2015).

This literature review aims to synthesize the information available about the course of eating disorders in adolescents, the available treatment options, and the use of drama therapy in the residential treatment of eating disorders. Recommendations for the use of role-based drama therapy work with adolescents in residential treatment are provided and topics for further research are proposed.

Literature Review

What is an eating disorder?

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) describes a feeding and eating disorder as "a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (p. 329). There are a total of six feeding and eating disorders listed in the DSM-5, but this paper will focus only on anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder as those are most frequently treated in adolescents at a residential level of care (Williams, et. al., 2020).

Anorexia nervosa (AN) is characterized by restrictive food intake and low body weight outside of the client's developmental context, which may include not meeting expected weight gain in children and adolescents. This behavior must also be met with cognitive disturbances in body image and a fear of gaining weight. AN has two subtypes; restricting type and binge-eating

and purging type, and symptoms typically begin in adolescence or young adulthood (APA,

2013).

Bulimia nervosa (BN) is characterized by recurrent episodes of binge eating followed by

inappropriate compensatory behaviors in order to prevent weight gain (APA, 2013). These

compensatory behaviors may include excessive exercise, laxative use, forced vomiting, and the

use of diet pills. BN symptoms are typically most severe in adolescence and early adulthood

(APA, 2013). According to the DSM-5 (APA, 2013), women are ten times more likely to be

diagnosed with AN and BN than men.

Binge eating disorder (BED) is characterized by recurrent episodes of binge eating

where the eating behaviors are abnormal, such as eating too fast, too much, or when not

physically hungry, and there are frequently negative emotions attached to the episode, such as

feelings of guilt or depression (APA, 2013). There is no typical age of onset for BED; symptons

can present at any point in the developmental timeline. People who experience BED do not use

compensatory behaviors out of fear of weight gain. According to the DSM-5 (APA, 2013), 1.6%

of females and 0.85% of males experience a diagnosis of BED in their lifetime, which has a

smaller gender ratio than AN and BN.

Otherwise specified feeding and eating disorder (OSFED) is a larger umbrella of

diagnosis for eating disorders that encompasses symptoms and characteristics of other eating

disorders that cause marked distress for the person but do not fully meet the criteria for a specific

eating disorder. Atypical anorexia is included in this category and is characterized by "excessive

weight loss that occurs very quickly via marked caloric restriction, even if the current weight is

not very low" (Trace, et.al., 2020, p. 626). This category also includes lower frequency BN and

binge eating, as well as purging disorder and night eating syndrome. Prior to the DSM-5, OSFED

was referred to as eating disorder not otherwise specified (EDNOS), and is therefore presented as such in any research prior to 2013.

Medical Symptoms

People diagnosed with eating disorders frequently show a variety of cardiopulmonary, endocrine, gastrointestinal, neurological, and rheumatological medical complications (Cass, et. al., 2020). These complications may provide treatment centers with information about what level of treatment the client should be receiving, but is not always reflective of their psychological needs for treatment. As the severity of the eating disorder progresses, the severity and number of medical complications also progresses (Mehler, et. al., 2018). Some of the more severe medical complications include, but are not limited to, malnutrition, dehydration, bradycardia, low vitamin D levels, low bone mineral density, and anemia. While these symptoms tend to be present in most clients with severe eating disorders, it is important to note that not all clients will experience the same symptoms.

Psychological Symptoms

Many people experiencing eating disorders also experience comorbid psychiatric disorders. These typically take the forms of mood disorders, anxiety disorders, behavioral disorders, and substance use (Halmi, 2013). Psychological symptoms that do not fully align with a comorbid diagnosis may also occur such as feeling a loss of control, lack of sense of self, perfectionism, negative body image, low mood, social isolation, executive dysfunction, fatigue, and alexithymia (APA, 2013). Similar to the medical complications listed above, clients with eating disorders may only present with some or may present with none of these psychological symptoms.

What causes eating disorders?

Some clients are predisposed to certain risk factors that can increase the chances of an eating disorder diagnosis. These risk factors can be genetic or environmental and most practitioners view eating disorder etiology in a biopsychosocial model to encapsulate the full range of possible sources (Trace, et.al., 2013). The biopsychosocial model holds the belief that one cannot point to specific causational factors in the development of eating disorders, but instead can attribute etiology to a combination of correlated factors that may provide evidence of future risk (Abbate-Daga, et. al., 2013).

Genetic Influences

According to the National Association of Anorexia Nervosa and Associated Disorders (ANAD), "28-74% of risk for eating disorders is through genetic heritability" (2020, para. 2). This large range of heritability covers a multitude of disorders and symptoms of disorders housed within the eating disorder category. The majority of genetic testing results regarding eating disorders have limitations on generalization due to their small sample sizes and a general lack of research in the eating disorder community. More molecular and linkage studies are needed in all areas of eating disorders in order to better understand the genetic underpinnings of eating disorders and how they interact with environmental factors.

Anorexia Nervosa. Clients with first degree relatives diagnosed with AN are eleven times more likely to have lifetime AN (Trace, et. al., 2013). Molecular genetics studies have found connections to symptoms of AN in the serotonergic and dopaminergic systems, as well as other genetic systems (Striegel-Moore & Bulik, 2007). All of these genetic systems influence mood and appetite regardless of external influences. Because of the addition of environmental factors and resiliency, indicators in these genes may not be strong predictors for the chance of AN to develop.

Bulimia Nervosa. According to Bulik, et. al. (2000, as cited in Trace et. al., 2013), "twin studies have yielded heritability estimates for BN ranging from 28% - 83% "(p. 597). Despite this confirmation that BN is genetically transmissible to some degree, association studies have not confirmed which specific genes may put clients at risk for BN, but "the choices of candidate genes in bulimia nervosa have closely paralleled those of AN" (Striegel-Moore & Bulik, 2007).

Binge Eating Disorder. Few genetic heritability tests of the full syndrome of BED exist. The few that do exist show a correlation between having a first degree relative with BED and a current diagnosis of BED in clients based on self-report measures (Trace, et. al., 2013). Additional studies have examined the heritability of specific symptoms within BED, such as the act of binge eating itself. "One population-based study of Norwegian twins between 18 and 31 years of age reported a heritability estimate of 41% for a syndrome that approximated BED termed binge eating in the absence of compensatory behaviors, with the remaining variance attributable to nonshared environment" (Striegel-Moore & Bulik, 2007, p. 190). This study may pave the way for more detailed heritability estimates of various symptoms of eating disorders, allowing researchers to look for interactions between gene and environment that may impact full syndrome cases.

OSFED. While the exact heritability of OSFED has not been tested due its large range of symptoms and subcategorization of symptoms, some genetic research has been conducted on the heritability of specific symptoms within the eating disorder syndromes, which might point to heritability of subthreshold eating disorders. Trace et. al., (2013) evaluated a variety of genetic studies related to eating disorders and found heritability estimates for specific compensatory behaviors of BN, binge eating, restrained eating, intentional weight loss, drive for thinness, and

binge eating without compensatory behaviors. More heritability studies are needed in order to determine the genetic influence on the entire syndrome presented in OSFED.

Environmental Influences

Because eating disorders are looked at through a biopsychosocial lens, it is important to note that influence from the environment is a determining factor in the development of eating disorders. Environmental influences affecting eating disorders come from culture, relationships, media exposure, and trauma.

Culture. A client's culture may contribute to their development of an eating disorder. Eating disorders are not culture bound and have been reported on every continent except for Antarctica (Levine & Smolak, 2010). "Western cultures are blamed for placing extreme value on physical appearance, particularly on body shape and weight" (Dakanalis, 2017). This beauty ideal is attached to gender roles and is therefore a more significant contributing factor for eating disorders in females (Levine & Smolak, 2010). As the western idea of thinness has become more available to other cultures, girls from non-Western cultures who have been placed in a Western culture seem to be more intensely affected by the societal standards of beauty. This may be due to adopting of Western ideals, but it may also be contributed to the stress of acculturation or the person's native culture (Levine and Smolak, 2010). Despite evidence of eating disorders occurring in a variety of cultures, they are most frequently diagnosed in non-Hispanic white women with a higher socioeconomic status (Obrien, et. al., 2017). Less frequent diagnosis in minority groups may be due to "lack of access to healthcare services" (Wood, et. al., Under Review) or low utilization of available services (APA, 2013).

In a cross-cultural study, Rodgers, et. al. (2020) used the Perceived Sociocultural Influences on Body Image and Body Change Questionnaire and the Sociocultural Attitudes

Towards Appearance Scale to measure societal pressures of beauty ideals and how much they are

internalized. Their findings suggest that there are varying levels of pressure from cultures to

adhere to thin beauty standards, but the most consistent across cultures was pressure from the

media (Rodgers, et. al., 2020).

  Social Media. Hesse-Biber, et. al. (2006) argued that "there are psychological reasons

contributing to eating disordered behaviors and other body disturbance issues" but that "clinical

factors alone cannot fully explain the burgeoning increase of disordered eating practices" (p.

209). Around the turn of the century, online social media networks increased in popularity. With

this, online health and wellness resources began to appear, further promoting societal ideals of

thinness and beauty and a weight-centered paradigm. "Messages about weight management

through diet and exercise are shared widely and receive high levels of engagement" (Marks, et.

al., 2020). These messages are influenced by the Western societal idea of thinness equating to

attractiveness (Harmon & Rudd, 2019). When engaging with social media sites, users that

participate in passive use, or only look at media but do not interact with it by liking, sharing, or

communicating with other users, and social comparison are more likely to experience harmful

psychological outcomes from their social media use (Marks, et. al., 2020). This engagement

leads to more negative body image and body comparisons, compared with viewing media images

of average sized models, plus sized models, and inanimate objects, and viewing such images

may lead to disordered eating (Morris & Katzman, 2003).

  Multiple studies have examined the effect of Instagram, a social media site for editing

and sharing photos, on the psychological wellbeing of its users, specifically influence on body

image (Marks, et. al., 2020; Prichard, et. al., 2020; Teo & Collinson, 2019). Instagram uses a

hashtag system to categorize pictures and make them searchable. Through this system, hashtags

specifically related to body image and inspiration for thinness have formed, including a hashtag

for "fitspiration," a combination of fitness and inspiration (Prichard, 2020). Exposure to these

images contributed to "a greater negative mood and body dissatisfaction" (Prichard, 2020, p. 4).

In addition to the communication of body and size ideals on social media, there has also

been an increase in "pro-anorexia" and "pro-bulimia" (also referred to as "pro-ana" and "pro-

mia") websites and social media profiles, which advocate for the use of disordered eating

behaviors (Burzekowski, et. al., 2010). The pro-ana and pro-mia movement "promotes a

managed approach to anorexia and has sought to re-define it outside medical or professional

discourses" (Fox, et. al., 2005, p. 945) and encourages participants to see eating disorders as a

lifestyle choice (Harmon & Rudd, 2019). These sites include images of people who fit the thin

ideal, calorie tracking methods, tips for continuation of starvation, and personal blog entries of

those participating in the sites. Themes of control, perfection, and motivation for continuing the

disorder are also present (Harmon & Rudd, 2019). "Harm from viewing pro-ana material for

women includes decreased self- esteem, appearance self-efficacy and perceived attractiveness, in

addition to an increase in perceived weight" (Bardon-Cone & Cass, 2007, as cited in Harmon &

Rudd, 2019, p. 247). The use of these social media sites may be contributing to the risk of

developing and maintaining eating disorders and discourage adolescents suffering from eating

disorders from reaching out for help from friends and family (Rouleau & Ranson, 2010).

Parent and Peer Attachment. Insecure attachment to both parents and peers also serces

as a risk factor for the development of eating disorders (Orzolek-Kronner, 2002; Cortés-García,

et. al., 2019; Gander, et. al., 2015) Attachment Theory, originally explained by Bowlby (1969, as

cited in Orzolek-Kronner, 2002), claimed that a child's behavior is not tied to physiological

drives but instead to desires for attachment to the caregiver and that the child forms internal

working models of behavior based on parental response. The child expresses these needs through

proximity seeking behaviors such as "sucking, crying, smiling, clinging, and following"

(Orzolek-Kronner, 2002, p. 424). "When caregivers are inconsistent or not available in

responding to the needs of their children, insecure attachment patterns may give rise to more

inflexible and self-critical IWMs [internal working models]" (Mikulincer & Shaver, 2012, as

cited in Cortés-García, et. al., 2019, p. 925). As the child develops, these attachments are made

with peers as well as caregivers. Insecure attachment, with parents or peers, may lead to poor

self-worth, interpersonal relationship problems, fear of rejection, impaired emotion regulation,

and body dissatisfaction (Kuipers, et. al., 2015; Cortés-García, et. al., 2019). In adolescents with

eating disorders, insecure attachment serves as a risk factor for development of the disorder

(Cortés-Garcia, et. al., 2019; Kuipers, et. al., 2015; Laporta-Herrero, et. al., 2021; Orzolek-

Kronner, 2002).

   Attachment Style to Parent as Risk Factor. In a review of existing literature about

attachment style and adolescents with eating disorders, Gander at. al., (2015), concluded that

insecure attachment was the most common attachment style amongst clients with eating

disorders. In a study done by Laporta-Herrero, et. al. (2021), adolescents with eating disorders

were found to have less trust and worse communication with their parents, as well as more

alienation with their fathers, compared to a cohort without eating disorders. Amongst the

participants in the eating disorder group that did not report insecure attachments with their

parents, there was a negative correlation between relationship with parents and body

dissatisfaction, leading to the assumption that insecure attachment leads to body dissatisfaction.

Cortéz-García, et. al. (2019), in a longitudinal study, also concluded that a better attachment to

the mother at an earlier age was a predictor of less disordered eating for both male and female

adolescents, and that a less secure attachment was associated with an increase in eating disorder symptoms. In the same study, more secure attachment to the mother was seen as a protective factor against disordered eating. The positive correlation between insecure attachment and disordered eating provides insight to attachment style influencing risk factors of eating disorders.

   Attachment Style to Peers as Risk Factor. As the child ages, attachment to peers becomes more important than attachment to parents (Marion, et. al., 2013; Sharpe, et. al., 2014), and "support and validation from peers over this time is particularly important to a healthy self-image" (Schutz & Paxton, 2007). In multiple studies, an association was made between poor peer attachment and increased eating disorder symptomology and body dissatisfaction (Sharpe, et. al., 2014; Schutz & Paxton, 2007; Laporta-Herrero, et. al., 2021).

   Schutz & Paxton, (2007), evaluated correlations of body dissatisfaction, positive and negative functions of friendship, and eating pathology in 327 grade 10 girls in Australia through a variety of self-report questionnaires, before and after controlling for depressive symptoms. The researchers found that body dissatisfaction and disordered eating were positively associated with negative aspects of friendship, specifically friend group preoccupation with weight and group perceived social advantages to thinness. In a similar study by Sharpe, et. al., (2014), 216 adolescent girls from age 13-16 were given self-report questionnaires to determine risk factors of peer attachment for disordered eating. The researchers found that girls who reported more disordered eating and higher body dissatisfaction also reported more negative functions of friendship, less positive functions of friendship, and more conflict amongst friends. This research points to a correlation between insecure attachment with friends and later development of disordered eating, but more longitudinal research needs to be done to determine causational direction.

Trauma. Sexual abuse and emotional and physical neglect/abuse in childhood are predictive factors of disordered eating later in life (Holmes, et. al., 2019; Vidaña, et. al., 2020; Strodl &Wylie, 2020; Gomez, et. al., 2021; Tagay et. al., 2014; Gander, et. al, 2015). However, noninterpersonal traumas, such as natural disasters, life-threatening accidents, or serious illness, are not associated with eating disorder symptomology (Gomez, et. al., 2021, Lejonclou, et. al., 2013). The relationship between trauma and eating disorder symptomology is strongest between trauma and bulimic symptoms, such as vomiting, laxative abuse, and over exercising (Vidaña, et. al., 2020; Lejonclou, et. al., 2013, Tagay, et. al, 2014).

Eating disorder clients with a history of trauma and post-traumatic stress disorder (PTSD) have more severe eating disorder symptoms, anxiety, and depression as well as worse treatment outcomes than eating disorder clients without PTSD (Brewerton, et. al., 2020; Tagay et. al., 2014). In a study conducted with 958 clients entering residential treatment, Brewerton, et. al. (2020) determined that those with a comorbidity of an eating disorder and PTSD had "more complex presentations" and were "more likely to have binge-purge features" (p. 2064). They also determined that these clients had a worse quality of life than those clients without PTSD. These findings supported previous research that determined clients who have experienced trauma are more likely to drop out of treatment and have higher relapse rates than those without PTSD (Tagay, et. al., 2014).

The relationship between the two diagnoses may be explained by the use of eating disorder symptoms "as a method of emotional numbing and/or coping method to avoid traumatic intrusions" (Vidaña, et. al., 2020). In a study done by Holmes, et. al. (2019), undergraduate women with high rates of disordered eating and some form of interpersonal trauma, define by Holmes as childhood physical, sexual, or emotional abuse or neglect or sexual or physical abuse

in adulthood, were given a variety of self-report questionnaires to determine the association

between trauma exposure, negative thinking schemas, and disordered eating behaviors. They

concluded that negative thinking schemas caused by trauma, "including ineffectiveness,

interpersonal problems, affective problems, and over control" (Holmes, et. al., 2019, p. 6), tie

trauma experiences to disordered eating behaviors. These negative cognitions contribute to the

development of eating disorder behaviors and symptoms.

Psychological Meaning of Eating Disorders

Eating disorders have a high chronicity rate and high relapse rate, which may be

attributed to by the positive psychological meaning that many clients give their eating disorders

(Gagnon-Girouard, et. al., 2019). They are considered egosyntonic disorders, meaning they are

ingrained in the client's self-concept (Strober, 2004) and are frequently seen to be of value by the

clients experiencing them, acting as a coping mechanism for a variety of negative affectual states

(Williams, et. al., 2016; Gagnon-Girouard, et. al., 2019; Holmes et. al., 2019; Halmi, 2013). In a

qualitative synthesis done by Espindola and Blay (2009), an evaluation of how clients interpret

their disease revealed that many clients saw AN as a part of their identity and a means of

controlling distressing external events in their lives.

Serpell, et. al. (1999) was one of the first studies to examine the psychological meaning

of eating disorders in clients with AN (Gagnon-Girouard, et. al., 2019). 18 clients wrote two

letters to their eating disorder: one as a friend and one as a foe (Serpell, et. al., 1999). The

researchers extracted ten positive themes from the friend letters and ten negative themes from the

negative letters based on a coding system that accounted for most frequent mentions within the

letters. The most popular positive attributes showed that clients related their eating disorders to a

guardian and gained control through their eating disorder behaviors (Serpell, et. al., 1999). These

positive attributes that act as resistance to treatment have been documented in several other studies as well (Williams, et. al., 2016; Halmi, 2013; Espindola & Blay, 2009; Stanghellini, et. al., 2012; Bouguettaya, et. al., 2019).

Identity

In eating disorders, there are a number of identity qualities that persistently occur such as perfectionism, the need for control, and the need for safety. Identity disturbance and lack of sense of self are both seen as features of eating disorders (Duffy, et. al., 2020; Williams, et. al., 2016). These disturbances stem from a negative public self-consciousness, assuming that others view primarily negative, usually inaccurate, traits about the individual, experiencing "their own body first and foremost as an object being looked at by another" (Stanghellini, et. al., 2012, p. 148). The eating disorder therefore becomes a way for the individual to define themselves for others (Williams, et. al., 2016).

Williams, et. al. (2016) used "a constructivist grounded theory methodology" that explored "the self within individuals with a lifetime of AN" (p. 213). The researchers identified five ways that clients with eating disorders related their identity to their AN: "AN taking over the self, AN protecting the self, sharing the self with AN, being no one without AN, and discovering the real me" (Williams, et. al., 2016, p.218) The clients in this study all reported using their AN as a way of forming an identity, and in turn becoming enmeshed with the identity of the eating disorder.

Perfectionism. Perfectionism is a piece of both personal and social identity that is heavily correlated with disordered eating and is a risk factor for the development of an eating disorder (Watson, et. al., 2011; Halmi, 2013; Joyce, et. al., 2012; Bouguettaya, et. al., 2019). In a study involving 201 women with clinically diagnosed eating disorders, Watson et. al. (2011)

found that self-oriented perfectionism, characterized by "setting unrealistic and excessively high standards for oneself," (p. 142) influenced the path and severity of the eating disorder, mediated by shape and weight overvaluation and conditional goal setting. These finding were repeated in a sample of nonclinical women in a community sample by Joyce, et. al. (2012), allowing for generalizability about the role of self-oriented perfectionism within disordered eating.

Socially prescribed perfectionism, understood as "the perception that others hold excessively high expectations for oneself couple with a strong self-desire to obtain these standards" (Watson, et. al., 2011, p. 142), is determined by social group belongingness and value of what is considered perfect within that social group (Bouguettaya, et. al., 2019). Within Bouguettaya, et. al.'s (2019) interviewing of ten women with eating disorders about perfectionism in their social groups, it was identified that these public and private standards for perfection were dictated through peer feedback within the group regarding weight loss and food choices. The limitation of size within this study lends itself to needing more replication but gives insight to where perfectionism may stem from within social surroundings.

Control

Eating disorder behaviors can be a way of controlling body shape and weight (Halmi, 2013), but can also be a means of gaining control during distressing external life events (Murray et, al., 2017; Espindola & Blay, 2009; Serpell, et. al., 1999; Holmes, et. al., 2019). For some clients, the need for control over their body is motivated by "a desperate attempt to compensate for an underlying sense of ineffectiveness and lack of control experienced in the rest of the individual's life" (Froreich, et. al., 2016).

Clients frequently see their ability to adhere to the strict rules of the eating disorder as a form of mental strength that exerts control (Gagnon-Girouard, et. al., 2019). By successfully

controlling their weight, individuals feel a sense of success when a sense of failure has shrouded

their previous attempts at controlling their life (Froriech, et. al., 2016). This feigned sense of

control may act as a resistance to treatment due to the positive value of control that individuals

place on their eating disorders (Halmi, 2013; Froreich, et. al., 2016; Williams, et. al., 2016).

Safety

Sense of control and identity enmeshment with the eating disorder can lead to the

individual seeing their eating disorder as a protector against the outside world (Serpell, et. al.,

1999; Wood, 2015; Williams, et. al., 2016; Knapton, 2013). The routine and rules associated

with the eating disorder create a sense of security and predictability in the client's life (Nordbø,

et. al., 2006). In the study done by Serpell, et. al. (1999) as well as the follow up study done by

Serpell and Treasure (2002), guardian was the most frequently reported positive attribute of both

AN and BN. These codes were identified by "statements involving ideas of being looked after,

kept safe, and protected" (Serpell, et. al., 1999, p. 180). This guardianship may be an external or

internal figure for the client (Knapton, 2013), and may be a factor in treatment dropout, poor

treatment outcomes, and higher rates of relapse amongst those with eating disorders (Stockford,

et. al., 2018; Norbø, et. al., 2006)

Treatment Resistance

Treatment dropout rates for eating disorders range from 20-70% (Fassino, et. al., 2009;

Abbate-Daga, et. al., 2013). Those clients with long lasting eating disorders with low motivation

to change may be considered to have a chronic disorder (Wonderlich, et. al., 2012; Stockford, et.

al., 2018). High attrition rates suggest that clients with chronic eating disorders have difficulty

accepting their illness and parting with it due to the positive attributes the disorder provides

(Wonderlich, et. al., 2012; Fassino, et. al., 2009). The psychological function of the eating

disorder as identity, control, and protection may serve this low motivation to change (Stockford, et. al., 2018; Serpell, et. al, 1999; Serpell & Treasure, 2002).

In a literature review done by Wonderlich, et. al. (2012), it was discovered that most treatments for chronic eating disorders focus on a multidisciplinary team that provides interventions that have not previously been done with the client. It is also suggested that goals be more focused on the psychological functioning of the disorder instead of focusing on weight and body issues alone. These finding corroborate the need for more client centered treatment described by sufferers of eating disorders in Stockford, et. al. (2018). More information is needed on best practices for treating chronic eating disorders, as there has been minimal testing on the efficacy of treatment planning done in the proposed way (Wonderlich, et. al., 2012).

Treatments available for people with eating disorders

"Services available for treating eating disorders can range from intensive inpatient programs…to residential and partial hospitalization programs to varying levels of outpatient care" (APA, 2010). Inpatient programs are typically aimed at weight gain and medical stability (Isserlin, et. al., 2020). Below that level of intensity are residential and day-treatment facilities (APA, 2010). Residential facilities typically offer 24 hours of care a day for clients who are already medically stable but need a more structured environment for reducing behaviors and obtaining psychological treatments. Day-treatment facilities, or partial hospitalization programs, are most effective when they offer eight hours of care a day for five days a week (APA, 2010). Less intensive levels of care include intensive outpatient and regular outpatient services (Peckmezian & Paxton, 2020; Twohig, et. al., 2015). Partial-hospitalization, intensive outpatient, and regular outpatient services focus mainly on maintaining nutrition and continuing individual and family psychotherapy (Dalle Grave, et. al., 2021).

Residential treatment is the level of care examined in the discussion and will therefore be the focus of this section of the literature review. Residential treatment "focuses more on long term therapeutic work" (Twohig, et. al., 2015). Many of these programs use a combination of family-based therapy, dialectical behavioral therapy, cognitive behavioral therapy, and various other techniques (Peckmezian & Paxton, 2020, Wilson, et. al., 2007) as well as non-traditional therapies such as expressive arts, art therapy, drama therapy, and many others (Twohig, et. al., 2015; Williams, et. al., 2020; Wood, et. al., 2015; Watson, et. al., 2011).

Family Based Therapy

Family based therapy should be considered the first line of treatment for adolescents with eating disorders (Muratore & Attia, 2021; Craig, et. al., 2019; Dalle Grave, et. al., 2021; Laporta-Herrero, et. al., 2021; APA, 2010). Family based therapy focuses on treating the family as a whole, while maintaining the idea that the family is not to blame for the child's eating disorder, and encouraging parents to take control of their child's eating (Jewell, et. al., 2016). Understanding the way that a family functions and engaging the family in treatment, including increased family visits, are essential for positive outcomes for adolescents in residential settings (Merritts, 2016). Family based therapy is performed in a variety of ways but usually follows the same basic tenets of putting the parents in charge of the child's recovery and then slowly allowing the child to have more freedom as recovery progresses (Jewell, et. al., 2016; Rienecke, 2017, Lock, et. al., 2010) Family-Based Treatment is a manualized, outpatient-based form of family therapy that has been proven to produce significant increases in weight gain and decreases in eating disorder pathology in adolescents with AN, and higher rates of abstinence from binge eating in adolescents with BN (Rienecke, 2017). It has been adapted to higher levels of care but

there is currently no evidence to support its efficacy over other forms of therapy, and it is typically not followed directly to the manual in these higher levels (Rienecke, 2017).

Family therapy for all diagnoses works in a similar way, just with different focuses in the initial phase of treatment (Jewell, et. al., 2016). For clients with AN or primarily restrictive behaviors, the initial focus is for the parents to take control of the child's eating in order to promote weight gain. For clients with BN, BED, and primarily binge related behaviors, the focus is on interrupting the disordered patterns of eating (Rienecke, 2017). The use of family therapy at the residential level prepares both the parents and the child for reintegration into the home after discharge (Merritts, 2016).

Cognitive Behavior Therapy

Cognitive behavioral therapy (CBT) is a popular evidence-based treatment for adolescents when used in combination with family-based therapy or when family-based treatment is not appropriate for the adolescent (APA, 2010; Muratore & Attia, 2021; Craig, et. al., 2019). CBT for eating disorders, originally designed for clients with BN (Dalle Grave, et. al., 2021; Ruggieri, et. al., 2021), is based in the idea that the core psychopathology of eating disorders is "related to overvaluation of shape and weight or judging one's self-worth mostly by weight and body shape, thus ignoring perceived performance in other domains of life" (Ruggieri, et. al., 2021, p. 151).

Cognitive behavioral therapy has been shown to increase weight gain and reduce eating disorder behaviors and attitudes (Craig, et. al., 2019; Linardon, 2018) and maintained or further improved this recovery at various intervals of follow up (Muratore & Attia, 2021). The first phase of therapy focuses on establishing the therapeutic alliance and monitoring eating behaviors (Ruggieri, et. al., 2021). Once appropriate weight gain has begun for needed clients, and a

trusting relationship has been established, the second stage may begin, focusing on the distorted cognitions that maintain the eating disorder. The final stage reviews progress and plans for recovery maintenance and discharge.

Cognitive Behavioral Therapy-Enhanced. Cognitive Behavioral Therapy- Enhanced (CBT-E) "is a personalized psychological treatment for eating-disorder psychopathology in general rather than specific to a particular DSM-5 eating-disorder diagnosis" (Dalle Grave, et. al., 2021, p.75). This approach is recommended by the National Institute for Health and Care excellence and shows promising results for all of the diagnostic categories of eating disorders (Dalle Grave, et. al., 2021). It includes a emphasis on "hindrances to change" (Ruggieri, et. al., 2021, p. 153). There is a focused version of CBT-E, which concentrates solely on core eating disorder psychopathology (Ruggieri, et. al., 2021; Linardon, 2018) and a broader version "targeting one or more of the associated problems" (Ruggieri, et. al., 2021, p. 154) in addition to the core psychopathology.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a form of cognitive behavioral treatment (Macpherson, et. al., 2013) that was originally developed by Marsha Linehan for use with women experiencing intense emotional dysregulation (Safer, 2017; Bankoff, et. al., 2012) that "results from repeated transactions between a biologically based emotional vulnerability and an invalidating social environment" (Clark, 2015, p. 185). It was originally developed as an outpatient treatment (Safer, 2017) but has since been adapted for multiple levels of care (Clark, 2015). DBT has been adapted for use with adolescents (Macpherson, et. al., 2013) as well as for adolescents specifically dealing with eating disorders (Bankoff, et. al., 2012; Salbach-Andrae, et. al., 2008; Safer, et. al., 2007). Many of these practices do not follow the exact DBT manual

(Macpherson, et. al., 2013), and are therefore considered "DBT-informed" (Clark, 2015, p. 192).

Because of the relationship between emotional dysregulation and eating disorders (Macpherson,

et. al., 2013; APA, 2013), the use of DBT-informed interventions for adolescents with eating

disorders is justified (Salbach-Andrae, et. al., 2008; Safer, et. al., 2007).

DBT-informed interventions typically follow the same basic tenets of manual-adherent

DBT (Clark, 2015), with adaptations made in several studies based on diagnosis (Bankoff, et. al.,

2012; Salbach-Andrae, et. al., 2008; Safer, et. al., 2007). Some of these modifications include the

removal of either individual or group sessions and the removal or addition of certain skills

modules (Bankoff, et. al., 2012). The four main tenets of DBT skills are mindfulness, distress

tolerance, emotion regulation, and interpersonal effectiveness (Clark, 2015, Salbach-Andrae, et.

al., 2008). The adolescent manual adds a fifth module called "walking the middle path"

(Macpherson, et. al., 2013, p. 72). The adolescent module has also been combined with the use

of art therapy for the treatment of eating disorders (Clark, 2015). The use of art therapy within

DBT promotes mindful participation in the skills learning activities and stimulates positive affect

in clients. "Although no formal, evidence-based protocol yet exists" (Clark, 2015, p. 191), there

are many therapists currently combining the use of art therapy and DBT for eating disorder

treatment.

Medication

There is limited evidence for the use of pharmacological treatment for adolescents with

eating disorders (Dalle-Grave, et. al., 2021). For clients with AN, selective serotonin reuptake

inhibitors (SSRIs) have not resulted in increases in weight gain, but, after weight restoration,

SSRIs may help improve mood and fluoxetine, specifically, may help prevent relapse (APA,

2010). Some evidence showed that the use of SSRIs, specifically fluoxetine, was beneficial in

initial treatment for clients with BN and BED (Wilson, et. al, 2007: APA, 2010)

Other Treatments

Existing evidence supports the use of bright light therapy for both AN and BN, but with

minimal studies being replicated it is still unsure whether this is generalizable (APA, 2010;

Isserlin, et. al., 2020). Many programs also incorporate therapeutic factors such as "adjunctive

meal support" (Isserlin, et. al., 2020), behavioral contracts (Williams, et. al., 2020), and

acceptance and commitment therapy (Watson, et. al., 2011).

Expressive Arts Therapies

Expressive arts therapies, also referred to in the literature as "arts therapy"(Frisch, et. al.,

2006, p. 132)," arts therapies" (Bucharová, et. al., 2020, p.1), and "creative arts therapies"

(Heiderscheit, 2015, p. 20), rely on non-verbal levels of communication and connection to the

body to explore psychological and emotional states and typically include visual arts,

dance/movement, music, and drama, as well as other forms of written, visual, and performance-

based arts activities (Bucharová, et. al., 2020). There is minimal empirical data supporting the

use of expressive arts therapies with eating disorders (Frisch, et. al., 2006), but "the qualitative

evidence cannot be easily dismissed and provides support for an evidence-based practice"

(Heiderscheit, 2015, p. 21). For the purposes of this paper, only drama therapy will be discussed.

Drama Therapy

According to the North American Drama Therapy Association (NADTA; 2021), "drama

therapy is the intentional use of drama and/or theater processes to achieve therapeutic goals"

("What is drama therapy?" section). The use of drama therapy with eating disorders typically

involves some aspects of psychodrama (Bucharová, et. al., 2020). Psychodrama is "an action

method [that]… teaches the importance of relationships and the social roles that we employ within these relationships" (Carnabucci & Ciotola, 2013, p.14). Using drama therapy with eating disorders can help externalize feelings through embodiment (Pellicciari, et. al., 2013; Wood & Schneider, 2015) and the use of role (Carnabucci & Ciotola, 2013; Wood & Schnieder, 2015).

An applied thematic analysis done by Wood and other researchers (Under Review) compiled considerations for the use of drama therapy to treat eating disorders. Their findings focused on four prominent themes: "challenges and necessity of embodiment with EDs [eating disorders]; conceptualizing EDs as intersectional; artistry of scaffolding DT [drama therapy] work for Eds; and navigating DT in ED treatment settings" (Wood, et. al., Under Review, "Results and Discussion" section. Para. 1). Clients with eating disorders frequently experience a mental separation from their body (Jacobse, 1994) so the use of embodied techniques is necessary for understanding emotion that is stored in the body (Wood, et. al., Under Review). It is also important for drama therapists working with eating disorder to recognize the intersectional identities of their clients to better inform individualized treatment plans. In the past, eating disorders have been considered to primarily effect white, middle class, females (O'Brien, et. al., 2017). In reality, there are a variety of ages, races, gender, and other identity sectors that are present in clients with eating disorders, and these factors influence the course of the disorder (Wood, et. al., Under Review). It is necessary for drama therapists to have an understanding of their own and other culture's emphasis on food and bodies in order to better help the client. Gradually laying the groundwork for drama therapy activities is also suggested by the researchers. This allows the client to establish an understanding of abstract representation and build trust in the therapist and the group (Wood, et. al., Under Review).

Pellicciari and other researchers (2013) investigated the use of drama therapy with adolescents diagnosed with AN. Their findings revealed that drama therapy was effective in increasing spontaneity, which "has been identified as a key factor in determining a positive change in the motivation to recover" (p. 611) as well as improving mood and ability to express emotions. Wood (2015) presented a case study of a young woman named Julie in residential eating disorder treatment that utilized embodiment, role work, and mask work in order to "help her develop a compassionate understanding of the function of her eating disorder" (p. 301). Within her drama therapy work, Julie is given the opportunity to play the role of her eating disorder, which allows insight into her internal emotional world and the protective role of her eating disorder. These case studies suggest positive outcomes from the use of drama therapy with clients with eating disorders but "quantitative assessments of the impact of embodiment and role techniques within this population are necessary" (p. 67) because case study data is not generalizable.

Role Theory

Role theory, developed by Robert Landy (Ramsden & Landy, 2021), posits that all humans take on and create roles in their life. The major tenets of role theory are roles, counterroles, the guide, story, and aesthetic distance. Roles are "discrete patterns of behavior that suggest a particular way of thinking, feeling, valuing, or acting" (Ramsden & Landy, 2021, p. 86) that fit into six domains of human functioning: somatic, cognitive, affective, social, spiritual, and aesthetic. Within the practice of psychodrama treatment for eating disorders, behaviors are treated as roles (Carnabucci & Ciotola, 2013). Counterroles are the other side of the role, not necessarily the opposite, and do not exist outside of the role (Ramsden & Landy, 2021). The roles and counterroles make up the dramatic content, also known as the story, and are integrated

by the guide, frequently embodied by the drama therapist. Distancing is the relationship to both the actor and the role and the actor, or group of actors, and the audience and delineates the balance of thought and feelings within the content. Overdistanced clients have "an overabundance of thought" whereas underdistanced clients have "an overabundance of emotion" (Ramsden & Landy, 2021, p. 91). Aesthetic distance, which is a balance of cognition and emotion, is the midpoint and is frequently the goal of role method (Ramsden & Landy, 2021). As well as identifying stuck roles and expanding the role repertoire (Pellicciari, et. al., 2013).

Role Method is "the practical application of role theory" (Ramsden & Landy, 2021, p. 83). There are two instruments used in Role Method to assess availability and use of roles within the client's repertoire: role profiles and Tell-A-Story. Role profiles are used to assess the quality and quantity of available roles. Clients are given a stack of cards with a variety of predetermined roles and asked to sort them into four categories: "I am this, I am not this, I am not sure if I am this, and I want to be this" (Ramsden & Landy, 2021, p. 91). The card sort activity is followed by a series of questions regarding the roles. Tell-A-Story is used to assess integration of the roles within the repertoire. The client is asked to tell the therapist a story with at least one character. The story can be an actual event or a made up story. After the client has told the story, the characters included are assessed as roles in terms of function, characteristics, and presentation (Ramsden & Landy, 2021).

Role-based therapies have little empirical evidence in their use with clients with eating disorders (Pellicciari, et. al., 2013; Bucharová, et. al., 2020; Wood & Schneider, 2015). The research that does exist primarily focuses on case study examination (Wood, 2015; Wood & Schneider, 2015; Pellicciari, et. al., 2013). Wood and Schneider's (2015) case study of a 19-year-old female with BN is the most relevant to work with role theory and eating disorders. They used

role-based techniques to promote neural integration. Neural integration creates cohesion of the

self and its interactions with psychological and social relationships (Wood & Schneider, 2015).

Through their work with role theory, they were able to conclude that "role-based techniques may

facilitate the process of neural integration" (Wood & Schneider, 2015, p. 67) in clients with

eating disorders, with more research needed to back up this work.

Discussion

Adolescents in residential treatment may play the roles of identity, control, and safety

through their eating disorders. These roles create a positive psychological meaning of the

disorder and create resistance to treatment. Through the use of drama therapy, these roles can be

explored outside of the eating disorder, perhaps lowering treatment resistance and attachment to

the eating disorder as a primary identity. Role-based work is recommended to begin at the

residential level of care. There is a heavy emphasis on group work at the residential level of care

and drama therapy is frequently presented as group interventions (Wood, 2015; Wood &

Schnieder, 2015; Pelliciari, et. al., 2010). The group structure provides additional support for

clients as they explore and expand their role repertoires together, as well as providing modelling

for each other for roles that may not exist in the repertoire yet (Ramsden & Landy, 2021). As

recovery progresses, the role work can be continued in lower levels of care as well. Based on the

literature, the author of this literature review makes the following is recommendations for future

work with adolescents in residential treatment for eating disorders: (1) more research about

treatment resistance in adolescents, (2) work with role and counterrole in order to expand the role

repertoire, and (3) a manualized way of working with role theory with adolescents with eating

disorders.

Treatment Resistance in Adolescents

Treatment resistance amongst adolescents with eating disorders is extremely high, particularly in adolescents with AN (Halmi, 2013). Much of the research that exists on treatment resistance is based on adult populations. Future research should focus on the factors of treatment resistance that are specific to adolescents. This should include a thematic analysis of both positive and negative psychological meanings of the disorder that adolescents hold. This could be done through a similar intervention as Serpell (1999) and Serpell and Treasure (2002), who had their clients write two letters to their eating disorder: one as a friend and one as a foe. This could be adapted to a drama therapy intervention through the use of the empty chair technique. The adolescent would sit facing an empty chair, and speak to the chair as if the embodiment of their eating disorder were sitting there. They would then switch chairs and respond from the embodiment and viewpoint of the eating disorder. This activity allows the client to see two different perspectives of their disorder and may begin the process of separating the role of the eating disorder from other roles that the client plays in their life.

Role and Counterrole

Drama therapy work will need to move slowly from concrete to abstract dramatic representations, allowing a groundwork understanding of drama therapy in the client (Wood, et. al., Under Review; Jacobse, 1994). As a basic understanding of the role process is obtained, and trust has been established in the therapeutic relationship and in the group, the client can begin to explore how their eating disorder has effected some of the roles in their limited repertoire, such as the roles of identity, control, and guardian. The eating disorder absorbs these roles, maintaining the eating disorder behaviors associated with them. These roles are played through the eating disorder and the therapist should challenge the client to play the roles without the influence of the eating disorder, establishing a counterrole to explore. There may be overlap in

the characteristics of the role and counterrole (Ramsden & Landy, 2021). By establishing a new

context for the role, and playing that out in the therapeutic space, the client can begin to

understand what new healthier roles can look like without the influence of the eating disorder,

and unlearn the positive psychological meanings of the eating disorder that are preventing

successful treatment and recovery. It is important to note here that the roles of the eating disorder

are not eliminated, they are adapted and expanded into safer, more flexible, and more effective

ways of interacting with their world (Carnabucci & Ciotola, 2013).

Manualizing Role-Based Work

Without a manualized way of conducting drama therapy with clients with eating

disorders, quantitative research regarding the effectiveness of drama therapy with these

individuals remains difficult. Wood and Mowers (2019) created "an operationalized model and

manual for therapeutic theatre as a specific intervention for those in recovery" (p. 218) which

provided evidence for the use of drama therapy with eating disorders. This intervention was only

used with clients who were considered to be in early recovery from their eating disorders and is

not intended to be used with clients undergoing more intensive treatments. Therefore the need to

manualize additional treatments at various levels of care for eating disorder treatment could be

valuable. More specifically, manualizing the use of role theory with eating disorders may create

a better system for calculating and analyzing roles present in the repertoire. This may take the

form of a role assessment, similar to role profiles, but with specified characteristics for

evaluating each role. Due to the interpretive nature of embodied work, the manualized role

profiles will need to set strict guidelines for which characteristics of a role must be present in the

clients embodiment of the role in order to be considered fully integrated. This assessment could

be given at the beginning and end of treatment. This process would also be useful for creating

treatment goals specified to role theory, based on the initial evaluation.

Conclusion

Adolescents with eating disorders struggle to recover due to the positive psychological

meanings that they ascribe to their disorder. Traditionally, adolescents in residential eating

disorder treatment are treated through FBT, CBT, and DBT, along with other multi-theoretical

approaches. Drama therapy, more specifically the use of role theory, could be a valid treatment

option for adolescents in residential eating disorder treatment because it provides a new

perspective on the role of the eating disorder. Through the use of role-based work, clients can

begin to identify how the eating disorder has influenced the roles they play in their life, and

begin to adapt these roles into healthier, more effective ways of functioning. As the client begins

to gain insight about these roles, they may begin to better understand the deterious effects of the

eating disorder on their lives, and be more willing to participate in treatment and recovery.

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