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Movement in Meal Time: A Movement Observation Assessment for Individuals with Eating Disorders

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Movement in Meal Time: A Movement Observation Assessment for Individuals with Eating

Disorders

Capstone Thesis

Lesley University

May 2, 2022

Ellery Mills

Dance/Movement Therapy

Carla Velazquez-Garcia

Abstract

This paper advocates for the use of dance/movement therapy (DMT) as part of treatment for individuals with eating disorders, while also proposing a DMT based method of assessment to be used with clients during meal times. This assessment, based on elements of DMT movement observation techniques, works as a tool to analyze the client's consumption behavior and level of risk, thus providing insight for treatment planning, goal setting, and themes for dance/movement therapy interventions. The proposed assessment was applied with an at-risk adolescent female during a lunch period in a school setting. The results of the assessment were then further processed and used to inform potential DMT based interventions that might help reduce thoughts and behaviors often associated with eating disorders. The assessment application and review experience highlighted the areas that were effective in evaluating risk and the nature of the participant's eating behaviors, proving to be helpful in better understanding the participant and their relationship with food. This experience also demonstrated the areas of its limitation and need for refinement to make this assessment even more effective for a wider range of participants and clinical settings. Relevant literature on the intersection of dance/movement therapy and eating disorder populations was explored thus further asserting the need and benefits of DMT based interventions for treatment of eating disorders and informing the development of the proposed assessment. Within this literature review, a variety of topics are examined including DMT treatment interventions, studies on the effects of DMT on body image, depression, and disordered eating, and key dance/movement therapists in this field who have developed universal themes for working with this population.

Movement in Meal Time: A Movement Observation Assessment for Individuals with Eating Disorders

Introduction

“The body itself must be regarded as a core element in the treatment of body image disturbance with eating disorder clients. How can we not recognize the importance of the body and the knowledge it holds? The body cries with pain or sorrow, trembles in anger, jumps for joy, leaps with excitement, slumps in defeat, and yearns for connection. The body and mind are interrelated parts that form a cohesive whole. They operate in a reciprocal manner. Body movements are influenced by our thoughts, attitudes and feelings; our thoughts, attitudes and feelings are influenced by the rhythm and the movements of the body” (Kleinman & Ressler, 2018)

Growing up as a dancer, I was no stranger to the impacts that dance had on body image, self esteem, and weight. I remember spending countless hours in a ballet studio and witnessing young dancers scrutinize their bodies, weight, and physique in the daunting floor length mirrors that covered the walls of the studio. Day in and day out, our bodies as dancers were critiqued, analyzed, and commented on. I recall on audition days, we would be observed with a watchful eye from the choreographer and instructor throughout the class. I would feel my heart beating as I would move across the floor. The judges would scribble down notes or whisper to their counterpart in secretive tones, all with a raised critical brow. My own critical thoughts would flood through my mind, and I wondered if the judges mirrored those same thoughts. The audition would often end with all the dancers lining up across the studio, standing shoulder to shoulder in front of the judges. In a straight line we would stand, pivot ninety degrees, pause, and pivot again so that the instructors could observe and assess each of us from all angles. Each of our bodies

being critiqued and compared as we anxiously awaited the results of the audition, wondering if we had made it. I would stand, mind racing, core pulled in and up, pelvis tucked, chin up, eyes forward, waiting to hear my name called.

As I reflect on this experience, I think about the other girls in that studio auditioning and dancing with me and how statistically, it is likely that many of them would develop an eating disorder if they had not already. Given that 700 million women in America have an eating disorder, it would be unsurprising that some, if not many, of the girls in that studio that I considered classmates, peers, and life long friends were struggling with poor body image, low self esteem, depression, restricted food intake, bingeing and purging behaviors, or disordered eating (South Carolina Department of Mental Health, 2006).

Although dancers and ballerinas are often susceptible to developing an eating disorder because of the high emphasis this art form has on body image and the idealized “dancer body” (typically considered thin, lean, flat, and short), this disorder is not unique to just dancers. Many individuals, both men and women, regardless of race, ethnicity, sexual orientation, gender identity, education, socioeconomic status, or family history, can develop an eating disorders throughout their life. According to the South Carolina Department of Mental Health, “One in 200 American women suffers from anorexia, two to three in 100 American women suffers from bulimia, and an estimated 10 – 15% of people with anorexia or bulimia are males” (South Carolina Department of Mental Health, 2006). These shocking statistics show the severity and prevalence of this disorder and knowing that eating disorders have the highest mortality of any mental illness, demonstrates the critical need for treatment for those struggling with this diagnosis (South Carolina Department of Mental Health, 2006).

Although there are a number of different treatment interventions and approaches for eating disorders, it is rare that a dance/movement therapy (DMT) approach is implemented as part of the individual's treatment plan. Though for some, the dance studio may have been the breeding ground for their eating disorder, it can also become a safe haven and a place of healing for those same individuals when DMT is effectively incorporated. Although it is not a typical form of therapy for this population, there are many benefits to the use of DMT. Due to the heavy emphasis on the mind-body connection within the DMT theoretical orientation, it can be highly effective in treating eating disorders and helping individuals once again find peace, security, and safety in their bodies.

Traditional forms of treatment for eating disorders, although important and effective, do not invite a holistic approach and allow for the client to reconnect with their body, which is integral to recovery. It is highly important for a client to re-establish feelings, somatic sensations, connections within their bodies, which is often dismissed and feared when an eating disorder is present (Krug, 2017). Furthermore, typical forms of assessments for eating disorders again do not recognize or incorporate elements of DMT such as body language, movement preferences, posture, or rhythmic movement behaviors that could be indicative of an eating disorder and should be considered given the physical nature of this disorder. Currently, there are no assessments that incorporate an expressive arts approach, specifically dance/movement therapy, and one that utilizes this approach would be highly beneficial to both the client and therapist.

It is my hope that in reviewing current literature on this topic and creating my own method of assessment, I can advocate for the use of DMT in the treatment of eating disorders and shed light on the importance of integrating this expressive arts approach into traditional treatment settings. I hope to learn more about specific dance/movement based interventions or

studies that could be helpful to this population and the ways that DMT can help alleviate symptoms and the presence of eating disorders in individuals with this diagnosis. Additionally, I have created my own movement based observation method to be used as an assessment for eating disorders. More specifically, this method is designed to be used during meal times as to assess an individual's movements, body language, and relationship to food during consumption. I also had the opportunity to apply my observation assessment with a participant and further analyze both the effectiveness and limitations of it in a real life setting. Ultimately, it is my passion and goal to provide more treatment options and ways of understanding this disorder so that individuals with this diagnosis can find the healing and acceptance in their bodies that they deserve and crave.

Eating Disorder Diagnoses

To first understand how eating disorders can be treated, it is important to know how to define and diagnose an eating disorder within a client. Anne Krantz defines an eating disorder (ED) as “disturbances of eating behavior and body image distortions with underlying psychodynamic, cultural, and gender conflicts” (Krantz, 1999). When assessing for a suspected eating disorder within a client, clinicians would look for a number of defining characteristics and indicators. According to the Diagnostic Statistical Manual of Mental Disorders 5th Edition, also known as the DSM-5, an eating disorder is “characterized by 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” (American Psychiatry Association, 2013). Within the umbrella of eating disorders there are a number of subtypes, each with their own notable symptoms, some more commonly known than others. Diagnoses such as pica, rumination disorder, and avoidant/restrictive food intake disorder are not as widely notable

but still fall into the DSM-5 eating disorder category. Disorders such as anorexia nervosa, bulimia nervosa, and binge-eating disorder are more easily recognized and treated more often.

Anorexia Nervosa

Anorexia nervosa is defined by a number of key diagnostic criteria one being the restriction of food and energy intake which leads to a significantly low body weight when considering the age, sex, developmental trajectory, and physical health of the individual (American Psychiatry Association, 2013). Additionally, individuals with this diagnosis have an intense fear of gaining weight or becoming fat. They demonstrate persistent behaviors that prevent and interfere with weight gain, such as excessive exercise, even though they have a significantly low weight already. Even when the individual does lose weight, these fears are not alleviated and at times may actually become worse. Finally, anorexia nervosa is defined by the individual's disturbance in the way they view their body weight or shape. "Some individuals feel globally overweight. Others realize that they are thin but are still concerned that certain body parts are 'too fat.' They may employ a variety of techniques to evaluate their body size or weight, including frequent weighing, obsessive measuring of body parts, and persistent use of a mirror to check for perceived areas of 'fat.' The self-esteem of individuals with anorexia nervosa is highly dependent on their perceptions of body shape and weight" (American Psychiatry Association, 2013). Within this diagnosis there are different levels of severity and risk based on the client's current BMI.

Bulimia Nervosa

Bulimia nervosa is defined by recurrent episodes of binge eating where the individual consumes a large amount of food, more so than most individuals would, and within a discrete and condensed period of time (American Psychiatry Association, 2013). With this, the individual

feels a sense of lack of control over their eating and cannot stop. Following this bingeing episode, the individual with this diagnosis fears weight gain and engages in behaviors to prevent gaining weight such as self-induced vomiting, misuse of laxatives or diuretics, and/or fasting and excessive exercise. The DSM-5 considers this diagnosis when these bingeing and purging episodes occur on average at least once a week for 3 months. Like anorexia nervosa, self esteem and sense of self is highly influenced by body shape and weight for individuals with bulimia (American Psychiatry Association, 2013). Also, notable, is the feelings of shame that often come with the binge eating behaviors. Individuals with this disorder tend to feel ashamed of their eating problems and attempt to hide their symptoms from others. Binge eating typically occurs alone and in secrecy and often continues until the individual is uncomfortable or painfully full. Preceding triggers that lead to a bingeing and purging episode might be interpersonal stressors, negative affect, dietary restraints, negative feelings associated with food, body shape or weight and boredom (American Psychiatry Association, 2013). Finally, the severity of this disorder is categorized by the frequency of bingeing/purging episodes the client displays per week.

Binge-Eating Disorder

Lastly, binge-eating disorder is defined in the DSM-5 again as recurrent episodes of binge eating, but is differentiated from bulimia by the absence of purging behaviors. Like bulimia, the individual with this disorder engages in bingeing behaviors where they consume an above average amount of food in a short period of time and feel as though they cannot control themselves or their eating (American Psychiatry Association, 2013). In binge eating disorder, the episodes are characterized by eating much more rapidly than normal, feeling uncomfortably full, eating large amounts of food without feeling hungry, eating alone due to embarrassment, and feeling disgusted, guilty, or depressed afterwards (American Psychiatry Association, 2013). To

meet this diagnosis, these episodes would occur on average at least once a week for 3 months and severity of this disorder is again recognized by the frequency of the episodes per week. As mentioned before, these binge episodes are not followed by purging behaviors or attempts to lose weight (American Psychiatry Association, 2013).

Causes and Comorbidities

Causes and the development of these three main eating disorders are similar in the fact that they all typically emerge in developmental stages like early adolescence or young adulthood, but late onset is still possible in some cases. Often these disorders are triggered by a stressful life event or trauma but environmental, genetic, temperamental, and physiological factors also play a role in the risk for developing one of these disorders (American Psychiatry Association, 2013). Individuals with anxiety, low self esteem, depressive symptoms, obsessional traits, or a history of trauma such as physical or sexual abuse are often considered high risk for developing an ED. Furthermore, these disorders are often paired with other diagnoses and comorbidities such as borderline personality disorder, bipolar disorder, obsessive compulsive disorder, anxiety, depression, and substance abuse disorder (American Psychiatry Association, 2013).

Traditional Treatment Options for Eating Disorders

Current treatment options for eating disorders are dependent on the type of disorder and its severity. Often, a clinical team is required for treating an individual with an ED. Counselors, psychiatrists, nurses, and nutritionists all work together to provide the best, well-rounded treatment for the client to tackle both the physical and mental symptoms of this disorder. The first step in determining treatment for an ED is diagnosing and evaluating the medical consequences that are exhibited. From here, the clinical team will assess the needs of the client and determine what level of care is necessary for combating the disorder and restoring the

client's mental and physical health. They must consider the psychological, biological, interpersonal, and cultural forces that are negatively feeding the client's disorder. Depending on the level of risk, different treatment settings would be appropriate, ranging from partial hospitalization, residential stays, or inpatient/intensive outpatient treatment.

Regarding psychotherapy and counseling treatment options, there are a number of approaches that are typically used for treating eating disorders. Therapeutic models such as Cognitive Behavioral Therapy (CBT), Interpersonal Psychotherapy (IPT), Family Based Treatment (FB-T) also known as Maudsley Model of Treatment, and Cognitive Remediation Therapy (CRT) are of the most widely used. Of these, CBT and IPT are the most common therapeutic interventions and have demonstrated success in treating anorexia, bulimia, and binge-eating disorder. CBT is a model of psychotherapy that targets distorted thoughts and maladaptive behaviors that maintain ED symptoms" (Kass et. all, 2014). The National Eating Disorder Association (DEDA) defines the CBT approach as "A relatively short-term, symptom-oriented therapy focusing on the beliefs, values, and cognitive processes that maintain the eating disorder behavior. It aims to modify distorted beliefs and attitudes about the meaning of weight, shape, and appearance, which are correlated to the development and maintenance of the eating disorder" (National Eating Disorder Association, 2022). IPT is similar but focuses on "targeting the interpersonal difficulties that maintain ED symptoms" (Kass et. all, 2014). The DEDA explains this model further in saying "IPT contextualizes eating disorder symptoms as occurring and being maintained within a social and interpersonal context. IPT is associated with specific tasks and strategies linked to the resolution of a specified interpersonal problem area. The four problem areas include grief, interpersonal role disputes, role transitions, and interpersonal

deficits" (National Eating Disorder Association, 2022). IPT focuses on communication and relationships to resolve interpersonal problems to reduce eating disorder symptoms.

Although treatment approaches such as these are effective and necessary for helping patients overcome their eating disorder, these psychotherapeutic interventions do not account for the role the physical body plays in their disorder. Models such as these focus solely on the mental nature of this disorder which albeit important, does not address the somatic reality of the ED. Treatment interventions that involve the body, like a dance/movement therapy (DMT), should be implemented when treating an eating disorder and used alongside models like CBT and IPT for a holistic, full mind-body approach. "We, as well as our clients, benefit from working within a holistic frame that reflects the powerful synchrony between body and mind" (Kleinman & Ressler, 2018). Current treatment methods recognize the need for nurses and nutritionists to aid in the recovery and physical health of the body from a medical perspective, therefore, it would be even more effective to acknowledge the body as part of the mental and emotional side of treatment as well, like DMT does.

The Basics of Dance/Movement Therapy

Dance/movement therapy, a form of expressive arts-based therapy, integrates the body into the therapeutic process in ways that traditional forms of talk-based therapy do not. DMT recognizes body movement as a form of expression and is based on the idea that the body reveals and communicates inner emotions when verbal language fails. Using the body to communicate is something integral to humanity and the body is our first tool for expression as infants. Therefore, it is important to maintain the use of this communication tool as adults and the body should still be an implicit form of expression even past childhood. The Association for Dance Movement Psychotherapy explains the field and form of therapy as a "relational process in which client/s

and therapist engage in an empathic creative process using body movement and dance to assist integration of emotional, cognitive, physical, social, and spiritual aspects of self” (Bucharova et al, 2020). More simply, the therapist opens the space for the client to use dance and movement as a means of expressing inner emotions and understanding themselves on a different and deeper level. When used alongside traditional forms of talk therapy, or other arts-based modalities, DMT can be a catalyst for healing and growth that begins in the body; the root and foundation for self-expression. Authors, Sharon Chaiklin and Hilda Wengrower, offer another explanation of DMT in their book, *The Art and Science of Dance/Movement Therapy: Life is Dance* written in 2015. Chaiklin and Wengrower write, “Creativity in the arts and in this instance, dance, is a search for structures to express what is difficult to state. Dance/movement therapy is based on the fundamental realization that through the dance, individuals both relate to the community they are part of on a large or smaller scale, and are simultaneously able to express their own impulses and needs within that group. There is shared energy and strength when being with others. It enables us to go beyond our personal limitations or concerns. Within the joy of moving together, we also experience the validation of our own worth and recognition of our personal struggles” (Chaiklin & Wengrower, 2015).

These writers also speak to the efficacy of dance/movement therapy in explaining key, foundational elements of this therapeutic intervention such as the concept of the mind-body connection. They write, “The mind-body concept has come full circle. All elements and components of a human are a set of related systems. Mind is indeed part of the body and the body affects the mind. Much research is now being done by neurophysiologists and other scientists to examine those interrelationships. When speaking of the body, we are not only describing the functional aspects of movement, but how our psyche and emotions are affected by

our thinking and how movement itself effects change within each of them and is affected in return” (Chaiklin & Wengrower, 2015). DMT is based heavily on this concept and is one of the few therapies that recognizes the connection and relationship between the mind and body.

Within the field of DMT, movement observation is an integral part of the therapeutic process. Movement observation in dance/movement therapy is when the dance/movement facilitator observes the movement pattern, styles, and preferences of the client, noting it and bringing it to their attention for further exploration. Typically, the client moves authentically and in an improvisational way, inspired by different prompts, feelings, concepts, or directives from the facilitator. The DMT, acting as the witness in the process, observes the clients and takes in how they are moving. They note areas of ease/resistance, different rhythms, speeds, tempos, directions, levels, and use of space or specific body parts. Collaboratively, they explore these preferences or movement styles with the goal of gaining a deeper understanding of themselves or working through an area of emotional challenge. The DMT is able to observe their client and see them on a different and deeper level, which may not be achieved through verbal conversation or written assessments. There are a number of movement observation frameworks which inform this process, like Laban Movement Analysis, the Kestenberg Movement Profile, the Africanist Aesthetic, and others. Frameworks like these shape and guide the DMT in their observation process and provide areas for notation and further exploration. Movement frameworks like these offer specific areas of observation and give meaning to what the DMT is noting and witnessing.

Pioneers in the Field

The development of DMT principles and practices like these stemmed from key pioneers in the field, all of which who recognized the healing power that dance/movement can provide. The use of dance and body movement as a cathartic tool is as old as dance itself. “In many

primitive societies, dance was as essential as eating and sleeping” (Levy, 1988). It provided individuals with a means to express themselves, to communicate feelings to others, and to commune with nature. Dance rituals frequently accompanied major life changes, thus serving to promote personal integration as well as the fundamental integration of the individual with society” (Levy, 1988). As society modernized, dance became viewed more as a performing art and less as a form of healing. Though, another shift during the first half of the 20th century began to bring dance back to its roots of healing and expression. From this shift came the genre of modern dance (Levy,1988). This style was, and still is, centered on expressive and authentic movement, as well as improvisation, spontaneity, and creativity, differentiating itself from other styles of dance which were based on strict technique and fundamentals. Key dancers in modern dance began to connect this movement style with conceptual developments in psychotherapy such as nonverbals, unconsciousness, and expressive parts of personality and behavior. Out of this conjoining intellectual climate of dance and psychotherapy, the field of dance therapy was born in the 1940's and 1950's (Levy, 1988).

Some key pioneers who are responsible for the development of this field include women such as Marian Chace, Blanche Evan, Lilian Espenak, Mary Whitehouse, Trudi Schoop, Norma Canner, and Alma Hawkins. Almost all of these pioneers began their careers as successful modern dancers and it was their experience as performers and educators that opened their eyes to the benefits of using dance and movement as a means of psychotherapy. These trailblazing women worked with a variety of individuals and served a wide range of populations making dance therapy accessible to both healthy and unhealthy minded clients. Through DMT, these women treated individuals suffering from schizophrenia, Alzheimer’s, autism, physical disabilities such as blindness, deafness, chronic pain, anorexia, closed head injuries, Parkinson’s

disease, drug/alcohol abuse, domestic violence, and trauma/abuse. These pioneers discovered that DMT was a powerful therapeutic technique to help with disorders like these because all have psychosocial components connected to physical issues (Chaiklin & Wengrower, 2015).

Susan Kleinman's DMT Concepts for Eating Disorder Treatment

Eating disorder populations can benefit greatly from the dance therapy process, which enables them to work directly with their bodies to alter distorted self-perceptions and therefore modify self-destructive behaviors (Levy, 1988). There is evidence-based research in this field which indicates that DMT can assist the patient with an eating disorder through reconnection to feelings, improve mood states, and increased self-awareness (Bucharova et al, 2020). Whether facilitated in individual sessions or within a group, DMT offers clients a safe way to reconnect with their bodies. Often, this is an area of discomfort and fear for them, as individuals with this diagnosis often avoid acknowledging feelings within their bodies. Through their disordered behavior with food and eating, they work to remove and isolate from body-based connections, feelings, and sensations. DMT works to combat this and these emotionally driven behaviors, like restricting food, bingeing and purging, or excessive exercise. It allows clients to discover the accompanying emotional components of their behaviors through the use of movement and patterns discovered on the body level. In other words, dance/movement therapy helps bring the unconscious thoughts and feelings driving the ED to the conscious level so that they can be further processed and overcome (Krug, 2017)

Authors, Monika Bucharová , Andrea Malá, Jir'í Kantor, and Zuzana Svobodová speak to this in their article, "Arts Therapies Interventions and Their Outcomes in the Treatment of Eating Disorders: Scoping Review Protocol" written in 2020. They explain,

The ability D/MT has to address body-related issues means it has the potential to be more effective than the current verbal therapies when the crux of the psychological state is manifested in the body. The body is the central battleground in EDs and as individuals focus on their thoughts, feelings are ignored. Ignoring feelings with processes that include and directly affect the body such as starvation, bingeing, and purging, amounts to burying the feelings through self-controlled physical sensation, the burial site being the body itself. Subsequently D/MT can be seen as a promising, but potent treatment intervention, which may not be applicable for all patients. The dance/movement therapists' role is to assist a patient with an ED to experience feelings and express them through their body language, with the aim of identifying connections between what they experience in the D/MT session and how it might reflect their lives. For this reason, the therapeutic alliance is a crucial feature as dance/movement therapists use the signals from their own bodies to respond to the expression of the patient. Developing a therapeutic relationship involves the resonance (attunement) between patient and therapist and can lead to the exploration of deeper, unconscious feelings that have been buried in the body (Bucharova et al, 2020).

A notable and recognizable pioneer working as a DMT with eating disorder populations is Susan Kleinman. She has been a board certified DMT and National Certified Counselor for over 50 years. Within this time, she has gained many notable publications and credentials including Certified Eating Disorder Specialist and Creative Arts Therapies Supervisor. Furthermore, Ms. Kleinman is a trustee of the Marian Chace Foundation, Past President of the American Dance Therapy Association, and past Chair of The National Coalition for Creative Arts Therapies. She is also the recipient of the American Dance Therapy Association's 2013

Lifetime Achievement Award, and The International Association of Eating Disorders Professional's 2014 Spirit of iaedp award. As a DMT, Kleinman is an integral member of the clinical team at the Renfrew Center where she works with women with eating disorders in a residential treatment facility in Florida.

Her recognitions, accolades, and extensive experience speak to her success as a DMT working in this population. Her development of interventions, theoretical frameworks, and DMT processes have shaped the way that dance movement therapists can offer healing to those with disordered eating. She is a powerful advocate for the use of DMT in ED treatment settings and supports her work with research, knowledge, and a lifetime of experience. One of her theoretical developments, known as the Cognitive Markers, informs the stages of the treatment process and grounds the work throughout the session. There are five stages to the Cognitive Markers which include exploration, discovery, acknowledgement, connection, and integration. These markers act as a guide throughout the session allowing the facilitator and the client to explore an experience or feeling in movement, make new discoveries from what's been explored, acknowledge that the discoveries are important, find meaning in the discovery and connect it with a familiar life pattern or experience, and then integrate the meaning of the connection in other areas of their lives so insight can be explored over time (Kleinman, 2018).

Another guiding development Kleinman has provided from her work with this population are the three main DMT concepts, known as rhythmic synchrony, kinesthetic awareness, and kinesthetic empathy. These are cues that the dance/movement therapist's experiences within themselves that helps them better connect with their client and inform the therapeutic process. The first concept, rhythmic synchrony, "represents the ability to be in tune with ourselves and our patients. This includes modifying our own way of being in our body including tone of voice,

speed of movement, and way of moving to attune to our patients” (Kleinman, 2018). This method of attuning to the client allows them to feel more connected, seen, and safe with the DMT throughout the session. Secondly, kinesthetic awareness, “refers to the ability to maintain conscious awareness of our ‘self’ physically, emotionally, and cognitively, while facilitating experiences that help patients experience their own feelings” (Kleinman, 2018). This allows the DMT to understand what they themselves are feeling on a body-based level in response to what their client is sharing to better understand and support them, as well as help them better understand themselves. The blend of these two concepts helps build rapport with the client and connect on a deeper level. The final concept, kinesthetic empathy, “manifests in our ability to foster shared expression by tapping into the patient’s issues in an embodied fashion and even sharing feeling states with them” (Kleinman, 2018). In other words, feeling what the client is feeling in their bodily sensations and emotions. These three main DMT concepts are integral to building connection with the client. These concepts foster a safe space where they can learn to tap into their body again with the guidance and support of the dance/movement therapist.

Susan Kleinman illustrates her work and use of the cognitive markers and three main concepts in her reflections of an experience with an individual client, Erin (not her real name). This vignette demonstrates a specific example of how DMT can be used to support a client using Kleinman’s theoretical approach.

“The more I try to control this anxiety, the more I lose control of it,” Erin said. “Trying to make a decision when I don’t know what to expect, causes it to increase even more. The doctor I saw this week asked why I was a bundle of nerves. I didn’t know it showed. I think I am disconnected.” Erin understood this in her head, but continued to fight her inability to connect her unconscious experiences with conscious awareness and thoughts.

She agreed to let me help her lean into sensations to embody and understand. This fit with the tenets of the mantra we had developed earlier regarding accepting her true self. We began by moving in circles that seemed never ending. “I don’t know how to stop,” she said, “and if I did, I wouldn’t know what to do!” Using my own *kinesthetic empathy*, I moved with Erin to understand what she was experiencing. As we shared our experiences, we expressed what it felt like to move in repetitive circles, not knowing when or how to stop. I became dizzy and nauseated; she remained unaware of what she felt. We created a goal to stop going in circles and move toward the other side of the room to symbolize Erin’s fear of facing the unknown. She protested, “How will I know when to stop?” “Listen to your body,” I responded. Eventually she stopped circling, put all of her weight on one leg, began shaking the free leg, and then brought it over on top of the standing leg that was trying to control everything. I tried to do this also to discover what I felt in my body. I recognized I felt a lot of tension from trying to maintain this position. Although Erin’s body shook from the stress of the position she attempted to hold, she repeated that she did not know what she felt. Again, we touched base cognitively to identify and connect what she was or was not feeling or thinking...I asked Erin to practice noticing when this pattern occurred during the week and to try to modify her usual ways of coping by using her new insights. Following our session, she wrote, “I am trying hard to just let myself be and trust that what happened in our session was supposed to happen rather than to engage in my usual over thinking that causes me to continue to move and think in circles.” Erin established a growing connection between her movement discoveries and her cognitive thoughts. Anchoring in this way also

provided her with a new reference to cope with the fears related to her past by making the unknown known, and the unconscious conscious (Kleinman, 2018).

Literature Review for Dance/Movement Therapy Interventions for Eating Disorders

“Re-Inhabiting One's Body: A Pilot Study on the Effects of Dance Movement Therapy on Body Image and Alexithymia in Eating Disorders”, researched and written by Maria Savidaki, Sezin Demirtoka and Rosa-María Rodríguez-Jiménez, further explores the efficacy of dance movement therapy interventions for the treatment of eating disorders. More specifically, how DMT aids in promoting better body image and the ability to express emotions verbally. These researchers explored the effects of DMT interventions with eating disorder patients over the course of 14 weeks of treatment. In their research, they worked with 12 eating disorder patients, 7 of which utilized the different dance movement based therapeutic interventions, and 5 did not. Additionally, both groups received the standard clinical treatment. At the conclusion of the 14 weeks, the results indicated an increase in body image with the 7 members that engaged in DMT exercises, while the 5 members did not feel an increased view of body image (Savidaki et. al, 2020). When testing DMT efficacy with alexithymia (difficulty recognizing, describing, or expressing one's own emotions), neither group increased significantly when measured with the TAS-20 both at the beginning and end of the trial. Though, it should also be noted that the DMT sessions increased the participants's self-awareness, improved their mood states, and promoted the building of meaningful relationships. This article concludes that the findings suggest that DMT could be helpful in the treatment of EDs on various levels (Savidaki et. al, 2020).

Another relevant article, written by Päivi Pylvänäinen, Katriina Hyvönen, and Joonas Muotka, focuses on defining features and comorbidities of eating disorders. “The Profiles of Body Image Associate With Changes in Depression Among Participants in Dance Movement

Therapy Group” written in 2020, provided insight into the connection of how dance movement therapy can improve low body image with patients with depression. This multi-method study analyzed the body image of 143 participants with depression, providing them with dance movement based group therapy two times a week. Using the Body Image Assessment (BIA), data was collected before, during, and after the study with the participants. The pre-intervention data collected from the BIA indicated that participants felt low energy, discomfort, shame and disgust towards their bodies, and tension in social interactions. “On the BIA scores, a statistical method of Latent Profile Analysis was utilized to identify participant profiles in the data. The two identified profiles were participants with initial negative body image and participants with initial neutral body image” (Pylvänäinen et al., 2020). It was found that depression symptoms decreased for both participant profiles after engaging with DMT interventions. These researchers' findings suggest a systemic interaction between depression symptoms, body image, attachment style, activity level, and mindfulness skills. In an interactive DMT setting it is possible to address all of these factors simultaneously (Pylvänäinen et al., 2020).

Thirdly, author Alexa Palmer reflects and writes on the experiences of working as a dance/movement therapist with eating disorder populations. In her article, “The Lived Experience of Dance/Movement Therapists Working with Patients with Eating Disorders”, Palmer explores 5 different DMT’s interactions and shared moments with ED patients. These experiences were researched and reflected through semi-structured interviews so that their thoughts and findings could be evaluated. Through these interviews reflecting on the DMT’s experiences, 7 key themes surfaced using Kvale’s interview analysis method. These 7 themes found included kinesthetic awareness, countertransference, somatic countertransference, boundaries, therapist’s body image, and both negative and positive experiences. Palmer’s article

touches on DMT interventions for eating disorder populations, the therapeutic relationship with patients, validation strategies, and transference/countertransference. More specifically, other findings from this qualitative study highlighted somatic countertransference as identified through differing body tensions. Additionally, this study spotlighted the importance of self care for the participants and bringing the body of the client and therapist into the treatment process.

Anne M. Krantz writes in the *American Journal of Dance Therapy* about her experiences in working with a 24 year old woman suffering from bulimia using DMT methodologies. “Growing Into Her Body: Dance/Movement Therapy for Women with Eating Disorders”, published in 1999, presents a model of treating eating disorders in women using dance/movement therapy interventions based on the work of DMT pioneer, Blanche Evans. Krantz describes Evan’s theoretical viewpoints and the method used specifically for women with this diagnosis. She goes on to write about the interventions and therapeutic approach she takes with her client, further illustrating the usefulness of this modality for this population. Krantz explains the rationale of this approach in her reflections stating, “the symptoms of eating disorders serve to disconnect affect from the body, particularly as sexuality, trauma, and cultural influences contribute to conflicts in the woman’s developmental struggle toward self-identity. Reconnecting the body with feelings allows the client to experience affect and express her inner world, to recognize meaning in her behavior and relationships, and to develop healthy psychological unity” (Krantz, 1999). Throughout the article, Krantz writes about the client’s case, the application of Evan’s approach, the specific DMT interventions used, and how this was helpful in the treatment of the client’s bulimia.

Also within the *American Dance Therapy Journal*, an article on movement observation analysis of individuals with anorexia is further explored. Written by Holly Burn in 1987, “The

Movement Behavior of Anorexics: The Control Issue” reflects on a pilot study done to explore the “control issue” of those struggling with anorexia through the use of movement and behavior analysis. In this study, Burns works with five hospitalized females, ages 17-22, who have been diagnosed with anorexia. She then compares their movement patterns to 5 females who do not struggle with this eating disorder used as a control group. In this study, the 5 women with anorexia were videotaped individually while performing 3 movement patterns, as well as the 5 women without this diagnosis. The movement patterns of the participants were then analyzed and compared by two movement analysts using the Reid-Ware Multidimensional Locus of Control scale. They noted distinctions in movement patterns between those with anorexia and those without. The results of this study did not reveal significant differences in movements when scaled with the Locus of Control scale, though it should be noted that there were a number of movement patterns that were reflective of those with an eating disorder. More specifically, researchers concluded that movements reflecting a lack of center, flow control, and distorted sense of time, weight, and space were all indicative of those participants who fell within the diagnosis of anorexia. Finally, Holly Burn concluded with theoretical interpretations of the findings of this study and the ways that it can be useful in the treatment of eating disorders, specifically anorexia.

Traditional Assessments for Eating Disorders

In order to properly diagnose and treat an eating disorder, a client would undergo an assessment, typically administered by a clinician or member of their clinical team. These evaluations, often questionnaire or scale based, would help indicate the type of eating disorder, the severity of it, and other contributing factors or comorbidities that might point to the presence of an eating disorder. Currently there are a variety of assessments that measure symptoms and

traits of different diagnoses, the level of risk, and thoughts and behaviors associated with eating disorders. Others assess level of self esteem or self-compassion, ability to regulate emotion, and perceived ability to control weight. A common assessment, The Eating Attitude Test, is a self-reported questionnaire ranging from 16 to 26 questions that measures eating thoughts and behaviors (Asl et al. 2021). Using a 6-point Likert scale ranging from ‘never’ to ‘always’, this assessment uses simple statements to evaluate four factors: dieting, self-perception of body shape, food preoccupation, and awareness of food contents (Asl et al. 2021). Another common form of assessment, used often because of its simplicity and brevity, is the SCOFF Questionnaire. This screening tool is made up of five questions; each affirmative response is scored one point and a score of two or more suggests a possible eating disorder (Read, 2021). The questions touch on the clients' relationship to food, their view of themselves and their weight, whether or not they make themselves sick, how much weight they have lost recently, and their control over eating. Screening tools and others like these act as helpful initial interventions for clients and indicate symptoms and behaviors of disordered eating, acting as a guide for further treatment.

DMT-Based Observation Assessment Method

As mentioned, assessments such as these are similar in the sense that they are often scaled and styled alike. They are typically self reported and use a ranged scale to assess the client in different areas. There is certainly a benefit to this, as it provides clear information and gives insight to the client’s perception of self and their relationship to food, weight, and body image. Although, in my research I found that many of these assessments covered the same symptoms and traits and did not account for other notable elements that might be helpful in the treatment of the client’s diagnosis. I found that there was no form of assessment for eating disorders that used

an expressive arts focus or lens. Although this would be an emerging approach, I would argue that there would be a benefit to incorporating the expressive arts into an assessment for eating disorders. This would not only expand that area of evaluation but also provide the client and clinician with a different method of observing and understanding themselves, their feelings, and behaviors.

More specifically, I would propose the use of dance/movement therapy concepts in an assessment, as it would help the client connect with their body and understand the physicality of their disorder in ways the self-administered questionnaires cannot do. As discussed, dance/movement therapy interventions help clients re-connect to their bodies and express themselves in different ways. Knowing that the body reflects the innermost feelings, it would be important to include this understanding in an assessment so that the client can be evaluated on a deeper, body level. When used alongside traditional forms of assessment, a DMT based assessment could add the missing elements that do not recognize the way that the body can communicate and reflect inner emotions.

With knowledge and understanding of movement frameworks and areas for observation within the field of DMT, I propose there is a need for a movement observation based assessment specifically for this population. More explicitly, I propose an assessment centered around meal times where a clinical team member could observe and document different aspects of the client while they engage with their food. I have developed a method of observation for this purpose which can be utilized at different stages of the client's treatment to offer measurable outcomes and observations. The observation-based assessment I have created is designed to be used to assess early risk and potential development of an ED. Additionally, it can be used at the start of treatment as part of the intake for a client already diagnosed, and then can be implemented again

at the end as part of an exit interview. The versatility of this assessment extends further and it can also be used throughout the treatment process as needed for benchmark purposes or to track the client's progress. The purpose of applying it would be to aid clinicians in identifying and/or understanding the client's ED diagnosis on a deeper level. Furthermore, this assessment could be used to inform treatment plans and goals, as well highlight areas that need additional attention through DMT interventions. Depending on the observations noted during the assessment, the therapist would be able to set and customize goals and dance/movement therapy interventions that would best support the client and their needs relating to their behaviors noted during meal times.

Through coursework in body movement observation classes relating to Kestenberg Movement Profile (KMP) and Laban Movement Analysis (LMA), I was inspired to create my own method of observation and turn it into an assessment to be used with ED populations. There are elements within my assessment that are inspired by KMP and LMA as these are foundational frameworks in observing and noting movements in the field of DMT. After synthesizing what I learned from these courses, I developed a method of assessment and then further refined it through continued research while also consulting with experienced DMTs who have worked with ED populations. It was my passion for this population, my interest in movement observation, and the lack of DMT based assessments that encouraged me to create my own intervention and implement it in a real clinical setting.

The method of assessment I have developed focuses on a number of key areas for examination related to elements of dance/movement therapy and eating disorders. While the client is engaging with a meal or snack, the clinician can observe how they are eating, their movements, and behaviors to get a sense of their relationship with food and potential areas of

struggle for them. Table 1 outlines the areas of observation and what can be documented during the meal time. The therapist that joins the client in their meal would observe and document what they noticed based on the questions listed and record what was seen in detail. Following the documentation, the DMT would reflect on what they observed both independently and perhaps with the client as well. Processing it together, the information gathered would then inform goals and interventions for the client's treatment.

Table 1

Time of Meal	<ul style="list-style-type: none"> -How long did it take to finish the meal? Short, long, in between? -Record start to finish time:
Expression While Eating	<ul style="list-style-type: none"> -What expression did the client have while eating? Flat affect, disgusted, sad, relaxed, eager, pleased, etc. -How would you describe the client's expression? Did it shift throughout the meal?
Posture and Body Language	<ul style="list-style-type: none"> -How was the client sitting/standing? -How were they holding their body? Slouched, closed, open, stiff, relaxed, etc. ? -Did you observe any fidgeting, anxious movements, obsessive behaviors, or excessive pausing? -Did you observe any other notable body language cues?
Speed and Rhythm of Consumption	<ul style="list-style-type: none"> -Observe the speed of chewing, swallowing, moving food to mouth, etc. -How would you describe the rhythm of consumption? Is the client eating quickly, slowly, with even tempo, irregularly, etc?

<p>Focus While Eating</p>	<p>-Was the client actively engaged while eating? Or were they distracted?</p> <p>-How was the client's focus throughout the meal? Were they talking, pushing food around, doing other things, focused, undistracted, etc.?</p>
<p>Conversation During Meal Time</p>	<p>-Was the client able to talk with peers/therapists during meal time? If so, what did they talk about?</p> <p>-Did their conversation revolve around food, calories, weight, feelings associated with eating, etc? Or did they discuss other things?</p>
<p>Behavior Following Meal</p>	<p>-Did the client leave quickly or linger?</p> <p>-Did the client ask for/seek more food or did they appear satisfied? Full?</p>
<p>Cultural Considerations</p>	<p>-What is the client's identified culture?</p> <p>-Does the client have any cultural values centered around food/meal times that would be important to note?</p> <p>-Describe any cultural traditions, behaviors, or rituals of clients' that should be defined and differentiated?</p>

Process of Assessment Application with Participant

I had the opportunity to implement my assessment with a participant I worked with through my internship site, under the supervision of a licensed professional counselor and board-certified dance/movement therapist. I specifically wanted to work with this individual because of how well they represent the kind of population that my assessment is intended for. My participant, an early adolescent female, had demonstrated a number of risk signs associated with

eating disorders. Although not formally diagnosed with an ED, she was a good candidate for further assessment given her gender, age, and trauma history, all of which are predisposing risk factors. Furthermore, she has other mental health diagnoses that are often comorbid with EDs, again putting her more at risk. Also notable are her frequent comments about weight, appearances, size, and negative body image, whether it be about herself or someone else. In the months that I have worked with her, there was rarely a time she did not make negative comments about her body demonstrating low self esteem and need for further assessment. Finally, I wanted to assess her because of her difficulty in managing and expressing emotions. In the past, when my participant would experience emotions that she did not understand or know how to express, she would become escalated and unable to control responses or behaviors. Challenged verbal emotional expression is again a sign that an ED could develop if she were to resort to controlling her food/weight instead of her feelings.

My participant, with her diagnoses, limited emotional expression, low self esteem, and trauma background, make her a great candidate for my assessment. With this tool, my aim was to gain a better understanding of her consumption behaviors and assess whether or not her low body image extends further into her eating habits, thus impacting her relationship with food in a risky way. My observation-based assessment is not limited to a case or individual such as this, but this was a good opportunity to use it as a means of assessing early risk to see if further intervention might be needed and necessary. To see how effective my framework proved to be, I invited her to join me for an informal lunch. I sat down for a meal in the afternoon with my participant in a private room, although I myself was not eating. I reviewed my assessment beforehand so that I would remember what areas I would need to be observing, but I did not want to have the assessment present with me in the meal because I did not want this to influence

the participant's natural consumption behaviors. I wondered how she might react to me joining her at lunch since this was not typical for us. I speculated that she might be self-conscious, nervous, or frustrated that her usual lunch routine was changed. Though, she was happy to let me join her and presented as her usual self which is social, excited, and engaging. We sat together at a table and she ate and talked with me through the lunch period while I mentally took note of her behaviors, body language, comments, expressions, and movements. Based on what I know of her, I suspected that she would demonstrate behaviors typical of an individual with anorexia nervosa. My knowledge of her case and the comments she frequently makes about her size and looks led me to expect her to demonstrate more restrictive eating behaviors. I predicted that she would show food avoidant behaviors such as playing with food or cutting it into smaller pieces. I anticipated that she might limit what she ate, restrict portion amounts, or throw some of it away. Before using my assessment with her over lunch I journaled about my predictions and noted certain restrictive behaviors that I might look out for. I refreshed myself on the different categories and questions outlined in the assessment I created so that I would not miss any areas of observation.

Following the meal, I quickly pulled up my assessment and filled in all the fields based on what I observed in the meal. I wanted to make sure I documented my findings shortly after our lunch so that the information was fresh in my mind. After noting my observations, I continued to journal in narrative-style as to further document the experience in full detail. I reflected on areas that I felt needed further observation as well as questions that came up for me during the assessment. Additionally, I processed and wrote about what came up for myself in the experience and noted any sensations, feelings, or thoughts in my own body that I had during the meal to bring in Susan Kleiman's concepts of kinesthetic awareness and empathy.

Assessment Results and Reflections

Much of what I observed led me to believe this participant is in fact at risk for developing an ED, and specifically shows signs associated with bulimia nervosa. I came to this diagnostic prediction based on the observations I noted that aligned with typical symptoms and behaviors seen in bulimia. Some observations that support this theory include the time in which she completed her meal. We had a 30 minute lunch period and she had finished eating what she wanted of her meal within 10 minutes. She started nibbling on her food as we walked down the hall to our room and consumed her food and drink quickly once seated. I noted that she sat down at the table with her food in front of her, her body facing towards me, and her feet flat on the ground. Additionally, her body language demonstrated that she was open, eager, and comfortable as evidenced by her sitting upright, close to her meal, and with her legs and arms uncrossed. She is a very naturally expressive individual and presented as excited, satisfied, hungry, and euthymic throughout most of the meal. She was smiling, bright eyed, and animated in conversation. I detected a shift in expression when I asked her if she was going to eat her salad and she shook her head, wrinkled her face up with a look of disgust, but then quickly shifted back to a happy expression.

Other observations that support my theory of diagnosis were noted in the rhythms, pacing, and patterns of her consumption. I saw that she ate rapidly, irregularly, and chewed and swallowed her food quickly. Sometimes she would bite and chew thoroughly but other times would switch to chewing while also picking up other bites with her fork and interrupting her first bite with another before swallowing. She moved seamlessly in her consumption and I noticed very little pausing or breaks between bites or picking up her food. I also noted she would eat with both her hands and her utensil, sometimes simultaneously. For example, using her hand she

would pick up her sandwich to bite it, while also using her fork to stab a fallen piece of food on her tray, preparing herself another bite at the same time. I did not recognize any obsessive behaviors or anxious movements while she ate and she remained engaged and conversational throughout her meal, discussing things such as her progress in school and the past weekend. She appeared satisfied and full after she had finished and did not ask for anything else.

One of the most notable and interesting parts of my assessment, which again led me to believe she is at risk of developing an ED, came from the comment she made towards the end of our lunch. She had finished all of her food, aside from her salad, and was playing with some pieces in the bowl. She stabbed a cherry tomato off the top and squashed it with her fork. She then proceeded to try and squeeze the squashed tomato through the small opening in the top of her empty milk carton. The tomato was resistant to fitting through the small container's opening and she was forcibly trying to push it through. As she attempted to shove it in, she made loud, tense comments about how the tomato was "too fat!" to fit through. She responded to herself expressively saying "don't call my son fat!" as she playfully imagined a story in her mind with a mother and her son, represented by the tomato.

Another part of my assessment observations that stood out to me was her behavior following the meal. Once she had finished eating, she got up quickly and went to the bathroom to wash her hands. I wondered if she was just simply washing her hands after her lunch or it was more a compulsive behavior, or even perhaps she was participating in purging behaviors while in the bathroom. Since she finished lunch early, she wanted to engage with me in some social play which I joined her for. We played together for about 20 minutes before the lunch period ended, and during this span of time she used the bathroom another 2 more times. Again, it was unclear

whether she was actually using the bathroom or if she could have been potentially purging, but nonetheless it was a cause for concern.

The results that my assessment yielded were very interesting and I found this tool to be effective in better understanding my participant. Although I was unsure of how well this assessment would translate into a real meal time with a future client, I was pleasantly surprised at how well it naturally produced results and offered insight into how I can better serve and support future clients. When all the areas of observation are combined from my assessment, it gave me a true representation of my participant's eating behavior, her relationship with food, and her risk potential. I believe based on my findings that my participant is at risk of developing an eating disorder with symptoms reflective of bulimia nervosa as evidenced by her quick rhythmic patterns seen in her eating, the lack of pausing between bites, her eager expression, her comments about size/weight during the meal, and finally her frequent trips to the bathroom after she finished her meal.

Had I not been able to apply my assessment with my participant, I would have still assumed she were at risk for developing anorexia, as opposed to bulimia, which her behaviors are more closely aligned with. I had predicted that she might demonstrate anorexic behaviors like eating slowly, fidgeting with her food, or displaying an expression of displeasure but instead I was wrong and my assessment provided more clarity and insight. I learned from this experience that it is important to do further assessment and not take someone for face value. Although I was basing my assumptions on what I knew of my participant, given her high risk demographics and negative comments of self, it was the experience of applying my assessment with her that offered the most information and accuracy.

Limitations and Areas of Refinement

To further process and better understand my findings, I consulted with my dance/movement therapist supervisor, who is an experienced DMT familiar with eating disorder populations. I reflected on my observations with her and she aided me in better understanding and conceptualizing what I had discovered with my participant. Together we explored how my assessment could be further refined and the areas that served me well, while also discussing the way my findings might inform future interventions. Although this assessment would be highly effective in eating disorder treatment in many ways, there are limitations to it, especially if applied in a clinical treatment setting.

In processing my findings, I noted one limitation could be that the client would likely be aware that they are being observed in their behaviors during meal times and may not move or eat naturally. Knowing that their movements are being examined and documented would likely cause the clients to feel anxious or self-conscious and therefore may not produce authentic results. It would be difficult to ensure that the client's behavior was natural and they were not changing, whether consciously or unconsciously, how they eat knowing they were being observed. Those with eating disorders tend to be uncomfortable with others looking at them or observing their bodies, therefore this assessment would be challenging for them and could limit the client's natural behaviors. With this in mind, it might be beneficial to invite the client into the process of assessment. It may be helpful to the client to feel like they have some control within the assessment by also offering them space for their feedback on the assessment experience. By welcoming the client to voice their own self-observations during the meal might help them to feel less like they are under the spotlight, and are instead collaborating with the therapist for the assessment. To reduce this potential limitation, I would recommend adding another section to the assessment that allows for the client to share their insights, feelings, sensations, thoughts, and

somatic responses so that they can be a part of the process and feel involved. Not only would this offer more potential comfort for the client, but it would also give more information to the clinician and provide them with further knowledge on the client's inner experiences. Adding this client perspective section would allow the therapist to review their witnessing with the client and hear their feedback and vice versa. Ultimately, it would create a more well-rounded assessment for both the therapist and client.

Another limitation with this assessment is the fact that it would need to be modified depending on the setting it is being used in and what is being assessed. Although it is versatile enough, there are some categories for observation that would need to be adjusted according to the treatment setting. For example, if my assessment were to be performed with a client who is in a higher level of care such as a residential center, there would be some differences due to the rules or expectations of the treatment center. Often long term treatment centers have specific guidelines that need to be followed during meal times that would impact some of the areas of observation with my assessment, specifically concerning the length of the meal and conversations during meal times. Typically, meal times are already set and clients are encouraged to finish their meals within the allocated time when in a residential program. When meals are not completed within the set time, the clients must supplement with meal replacement shakes. Additionally, many treatment centers have rules around talking about food, weight, and calories during meal times. These are examples of ways that the specific treatment programs or expectations of the clinical team might impact the way the assessment is performed and received. With this in mind, it would be important that the DMT review the policies of the treatment program before implementing the assessment and make the proper changes in order to best assess the client.

Assessment Informed DMT Intervention for Participant

Based on the observations noted in my participant during the assessment process, I believe she would benefit from some early DMT interventions as to hopefully avoid any further development of eating disorder related thoughts and behaviors. If given the opportunity to work with my participant using DMT interventions, I would allow the results of her assessment to inform the type of intervention I might implement. I would note key themes throughout the assessment results and translate them into DMT based exercises that would help address some of the bulimia related behaviors noted in our lunch period. The goal being to use dance movement therapy exercises to overcome negative behaviors observed that are likely showing up in other areas of the participant's life, perhaps further contributing to her risk of developing bulimia.

For instance, a common theme throughout the participant's assessment results was her quick, hurried, and rushed rhythmic patterns seen in their chewing, swallowing, or utensil movements. With this in mind, perhaps we would work on DMT exercises that focus on slowing down using moderated, more even paced rhythms. First, I would encourage my participant to join me in a meditative practice known as a body-scan. Starting from her toes and moving slowly up to her head, I would encourage her to check in with each part of the body and focus her attention on any sensations, feelings, or thoughts that arose in that part of her body. This would allow her to practice slowing down, being mindful, and reconnecting with her physical self. Following this, I might use some gentle, soft music and ask her to show me how she might move slowly, leisurely, and evenly, while I mirror back her movements in my own body at the same time. Perhaps we would then switch roles and she would mirror my slow movements. Our movements would be improvised, explorative, and authentic meaning there would not be pre-set or choreographed movements. Together we would explore in dance what slowing down feels like

in the body, while mirroring one another thus creating connection and attunement. I would offer up imagery to help encourage the use of slow movements such as encouraging her to imagine we are dancing in slow motion or through sticky honey. I would also offer even paced rhythms for her to mirror like soft side-to-side swaying or waves. Additionally, I might also encourage her to incorporate her breath and slow down the rhythm of her breathing with her movements. To further enrich the intervention, we may explore the contrasting movements and I would encourage her move quickly, erratically, and rushed so she can feel the difference in her body to compare.

This exploration of slow movement would demonstrate to me how my participant understands the idea of slowing down which could lead to richer conversation. I might prompt a discussion about how this might have felt for her and what came up for her in this investigation of movement. I would ask her what areas of life she feels like she needs to slow down or what makes it challenging to slow down. Together we could discuss which movements, either slow or fast, made her feel safer, more in control, comfortable, or relaxed and once again connect this to other areas of her life. This is an example of a hypothetical dance/movement based intervention that might be beneficial to the participant based on the results of her assessments. More interventions could be developed, again inspired by different observations documented in the assessment, thus leading to more conversation and openness from the participant.

Conclusion

Through my research for my capstone thesis project: development of a method, I found there was a lack of DMT based interventions for assessing and treating eating disorders and I recognized the need for developing one. It was my hope to further advocate for the use of dance/movement therapy in treating eating disorders and provide resources based in DMT to

support this population. In reviewing relevant literature on this topic, I was able to synthesize what methods, research, and interventions have been developed thus far in bridging the gap between dance/movement therapists and clients with eating disorders. From here I reflected on what was still needed to bring more healing to this population and I developed my own movement observation based assessment and applied it to an individual who I believed would benefit from it. This experience not only helped me better understand my participant and her needs, but also showed me the areas in which my assessment can be helpful and how it might need to be further improved. With further refinement, my goal is that this assessment could be implemented in a variety of treatment settings and become a helpful tool in supporting clinicians in understanding their client's consumption behaviors, diagnosis, and treatment prognosis. Eventually, it would be beneficial to apply this assessment with a client already diagnosed with an eating disorder who is presently in a treatment program. This would be done to see how my assessment might be effective in a clinical treatment setting and how it differs from the experience I had implementing it with my participant through my internship site to assess risk potential. In the future, I hope to use my assessment with a client during a meal in a residential treatment facility and then work directly with that client using DMT based interventions that have been informed by the results of their assessment. Future experiences and developments such as this would shed light on the ways that dance/movement therapy could be helpful in the healing process of individuals with eating disorders and feed both their physical and emotional hunger.

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THESIS APPROVAL FORM

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Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Dance/Movement Therapy, MA**

Student's Name: _____ Ellery Mills _____

Type of Project: Capstone Thesis Project: Development of Method

Title: Movement in Meal Time: A Movement Observation Assessment for Individuals with Eating Disorders

Date of Graduation: _____ May 21st 2022 _____

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: _____ Carla M. Velázquez-García _____