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THE USE OF THERAPEUTIC THEATER IN SUPPORTING CLIENTS
IN EATING DISORDER RECOVERY AFTER INTENSIVE
TREATMENT: A QUALITATIVE STUDY

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A Dissertation Submitted to The Graduate School
at the University of Missouri-Saint Louis in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in Education
with an emphasis in Counseling

May, 2016

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Abstract

In 2007, Wilson, Grilo, and Vitousek made a call for researchers to increase the research for eating disorders, declaring that counselors are “well positioned to make important contributions to the study of eating disorders” including exploring and identifying the “mechanisms of therapeutic change” (p. 212). The purpose of this qualitative research study was to explore experiences of participants who were part of an experimental therapeutic theater project after receiving intensive treatment for an eating disorder and to examine how the project benefited their recovery process. The research question was, “In what ways can therapeutic theater support clients in their first year after discharge from intensive treatment for an eating disorder?” This research aimed to examine the potential benefits of therapeutic theater, as well as to answer Wilson et al.’s call for counselors to study factors associated with therapeutic change for persons in recovery from an eating disorder.

DEDICATION

This research is dedicated to all those who are in recovery from an eating disorder.

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CHAPTER 1:

INTRODUCTION

Over the past 6 years, I have worked as a counselor, specializing in drama therapy, at an intensive treatment center for eating disorders in Ballwin, Missouri. Unlike most of the therapists in our treatment center who work at one level of intensive care, I have had the unique privilege of working with clients through all levels of the intensive care treatment process. These levels include residential treatment, day treatment, partial hospitalization treatment, and intensive outpatient treatment. These phases of treatment have evolved over the years, nationwide, as a means of helping titrate the spectrum of work that must take place in order to help clients work through the complexities of an eating disorder.

Through my years of work, I have become acutely aware of the differences between each level of intensive care for clients with eating disorders. While treatment varies among different eating disorder programs across the nation, in general, each level of care has an industry standard. In residential treatment, clients need to gain stabilization from their eating disorder behaviors (e.g., bingeing, purging, and restricting) and understand the protective function of the addiction. In partial hospitalization, clients practice mindful eating and have more autonomy and freedom with food. At this stage, they begin to work through wounds of their past that contributed to the need for the eating disorder. In transitional living, clients work to integrate more foods, take self-responsibility, and begin to redefine who they are as people in the world without the eating disorder. Finally, in an intensive outpatient environment, clients work to re-

integrate into the world, perhaps by working part-time, and continue to redefine their relationship with food, their bodies, and the world at large.

I have watched so many clients leave the final stages of care with hope and optimism. However, through the years, many of those same clients have come back through the doors of treatment due to serious relapse. Witnessing the relapse pattern ignited a fire within me. Why were so many of my clients who had such extensive practice and success in intensive treatment struggling so profoundly after treatment? I began to informally ask this question, both during our alumni weekends and when clients relapsed. Repeatedly, I heard clients report that the shift from intensive levels of care, despite the fact that titration was already built into the program, were not enough to prepare them for the challenges of the real world. Clients reported feeling lonely, lacking support and feeling uncertain about their lives without an eating disorder. As I began to research, I found that what my clients reported was congruent with what the literature provided: most patients are at their highest risk for relapse in the first 6 to 12 months after intensive treatment (Woodside, Kohn, & Kerr, 1998). The literature urged for research to be conducted not only exploring causes of relapse, but also the design, implementation, and study of “follow up treatments to help individuals with eating disorders overcome their illnesses” (Woodside et al., 1998, p. 233).

These personal experiences, backed by my informal research, propelled me into the idea of creating a theater group for clients after intensive treatment using a model of drama therapy known as therapeutic theater, in which the employment of theatrical performance is utilized as a method of therapy (Snow, D'Amico, & Tanguay, 2003). The theater group is aptly named Recovery Through Performance, and persons after intensive

treatment for an eating disorder work to write and to perform an original play for the community based on the complexities of the recovery process. The experimental pilot of this project was met with overwhelming success, with participants commenting that it was a life-changing experience and significant contributing factor to their recovery process. Thus, the purpose of this basic qualitative study was to formally explore the use of therapeutic theater as a model of treatment that supports clients working on recovery from an eating disorder within the first year after intensive eating disorder treatment.

In the following section, I lay out preliminary relevant information to orient the reader, as well as define key terms necessary for the reader to understand before the in-depth literature review in Chapter 2. Discussed below are the different types of eating disorders, as well as the definition of eating disorder recovery and eating disorder relapse. After that, creativity in counseling and drama therapy are described to create context for the specific type of creative intervention being utilized: therapeutic theater and the co-active therapeutic theater model, which are also described. Finally, I define qualitative research and present the research questions of this study.

Eating Disorders

Eating disorders, as defined by the American Psychological Association ([APA, 2013) in the Diagnostic Statistical Manual, Fifth Edition (DSM 5), include anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder, and eating disorder not otherwise specified. AN “is characterized by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat” (APA, 2013, p. 337). BN is “characterized by frequent episodes of binge eating followed by

inappropriate behaviors such as self-induced vomiting to avoid weight gain” (APA, 2013, p. 345). *Binge eating disorder*

is defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control. . . . The disorder is associated with marked distress and occurs, on average, at least once a week over three months. (APA, 2013, p. 351)

Persons can be diagnosed with one type of eating disorder or, more commonly, vacillate between two classifications of an eating disorder.

Statistics show that individuals with eating disorders have a higher mortality rate than those with any other mental illness (Pinto, Guarda, Heinberg, & DiClemente, 2006). AN and BN are “chronic psychiatric disorders that are further complicated by high relapse rates and persistent subthreshold symptomatology” (Pinto, Guarda, Heinberg, & DiClemente, 2006, p. 376). Even though there has been considerable growth over the last 25 years in courses of treatment for different types of eating disorders, there is still a large gap in what is known to be an effective treatment (Fairburn & Harrison, 2003). As Jones, Harris, and Leung (2005) confirmed, “Unfortunately, our ability to predict the course of eating disorders, to treat them efficiently and effectively prevent relapse remains limited” (p. 237).

Public interest in eating disorders and common misunderstandings about the disorders far outweigh the research being conducted in eating disorder treatment. In fact, most research is housed in psychiatry departments of medical schools (Wilson, Grilo, & Vitousek, 2007). In 2007, Wilson et al. made a call for researchers (other than medical researchers) to increase the research of eating disorders, declaring that psychologists and counselors are “well positioned to make important contributions to the study of eating disorders . . . including exploring psychobiological mechanisms that cause and maintain

eating disorders, and identify the mechanisms (mediators) of therapeutic change” (p. 212).

Recovery from an Eating Disorder

One of the most complex issues in understanding therapeutic change in the treatment of eating disorders is that the research community cannot come to “a clear, consistent, and measurable definition of recovery from eating disorders. . . . We can’t assess something which is not clearly defined” (Noordenbos, 2011, p. 447). There is still “no consensus definition of remission, recovery and relapse” (Von Holle et al., 2008, p. 108) accepted by the field, and “the process of recovery remains poorly understood” (Keski-Rahkonen & Tozzi, 2005, p. 83). Qualitative and quantitative research on recovery has, at a minimum, come to the conclusion that recovery must be defined as more than just a reduction of eating disorder symptoms, but must also include a wide spectrum of a person’s quality of life and capacity to engage in the world (Noordenbos, 2011). Noordenbos (2011) created a taxonomy based on client and therapist perspectives that capture the many dimensions that necessitate recovery:

1. *Eating and drinking*: eats three regular meals a day; number of calories is appropriate for height, age, and gender; no binges; no vomiting; no laxatives or diuretics; no slimming pills; drinks enough liquid; does not dehydrate herself in order to weigh less; does not drink large amounts of water in order to vomit more easily; does not drink alcohol in order to reduce negative emotions.
2. *Physical activity and exercising*: is no longer hyperactive; and no longer exercises extremely to lose weight.
3. *Attitude towards food*: has a relaxed attitude towards food; dares to eat all kinds of food and no longer divides food into good and bad food; enjoys eating with others; is no longer obsessed by food and weight; does not punish him/herself after food intake.
4. *Body evaluation*: does not feel too fat; has a positive attitude towards her body; accepts her figure; does not feel the need to lose weight; has a relaxed

attitude towards her weight; has a healthy attitude towards her body; no longer criticizes or ignores her body; is able to listen to the needs of her body.

5. *Physical recovery*: has a normal weight for age and height; weight is stable; body temperature is normal; heartbeat and pulse are normal; no constipation; no disturbances of the intestines or the stomach; no dried skin; regular sleeping pattern; not often tired; has enough energy.
6. *Psychological recovery*: has developed a “sense of self”; has self-esteem and a positive evaluation of her self; has enough self-respect; has a positive attitude of herself; self-esteem is not dependent on weight or food intake; has a positive feeling of identity; is assertive enough to express her own opinions; is no longer overly dependent on the opinion of others; has a feeling of autonomy; is able to concentrate; has no maladaptive cognitions about food, weight, herself, her body, or others; is not overly perfectionistic; has no extreme fears of failure; has a realistic self-image.
7. *Emotion regulation*: no longer avoids or suppresses her emotions, feelings or needs; is able to recognize and express her emotions and needs; is able to cope with negative and positive emotions; is able to cope with conflicts instead of avoiding them; has a positive attitude toward spontaneity and pleasure.
8. *Relaxation*: has no feelings of extreme restlessness or inner tension; is able to relax her body; can cope with psychological stress without binges; has a relaxed attitude towards her life; and is not rigid or obsessive-compulsive.
9. *Social relations*: participates in social activities; is able to establish social contacts and to make friends; feels comfortable in contacts with others; is no longer socially isolated.
10. *Sexuality (dependent on the age of the person)*: is no longer afraid of intimacy, erotic situations, or sexual behaviour; is able to express her own wishes about sexuality; is no longer afraid to lose her identity in intimate relations; enjoys intimacy and sexuality.
11. *Comorbidity*: has no other psychiatric disorders that are related to ED, such as anxiety disorders, depression, self-injury, obsessive-compulsive behaviour, or post-traumatic stress disorder. (Nordenboos, 2011, p. 244)

The dimensions of recovery from an eating disorder are complex. Multiple research studies could be conducted on any of these categories. Currently, a multi-million-dollar industry exists to treat eating disorders. Inpatient hospitals, residential treatment, partial hospitalization programs, and intensive outpatient programs all exist to help treat persons

with eating disorders in an intensive format. However, few programs are comprehensive in treating all of these subsets of recovery.

Relapse After Intensive Treatment From an Eating Disorder

Like defining recovery, the field also struggles with defining a relapse. For purposes of this study, *relapse* was defined as any symptoms of eating disorder behaviors (e.g., restriction, bingeing, purging, excessive exercise) that becomes an impairment to a person's life and causes him or her to need to seek a higher level of care than outpatient treatment.

It is important to note that the continued emphasis on symptom reduction drives the eating disorder industry, as insurance mainly pays for coverage on weight gain (for AN) and behavior reduction of bingeing and purging (for BN) primarily. This limitation is problematic, as most relapses occur within the first year of recovery (McFarlane, Olmsted, & Trottier, 2008). The most commonly reported feelings by persons with an eating disorder that are linked to relapse postintensive treatment include loneliness, lack of therapeutic contact, lack of relationships, anxiousness or nervousness about the recovery process, and lack of empathetic understanding and support (Keski-Rahkonen & Tozzi, 2005; Woodside et al., 1998).

These reports make sense because, when clients are in higher levels of eating disorder care, they have therapeutic contact, relationships, and support staff all built in. That is to say, in higher levels of care, all of the struggles during recovery do not have to be addressed because they are inherently a part of the program. Clients are required to attend daily groups and weekly therapy sessions, ensuring therapeutic contact. Many people are in a program, which creates fertile ground for relationship building. Support

staff is available, somewhat on demand, to help combat anxiety or fear. All of these outlets provide clients with easy access to support and empathy. After intensive treatment, clients most typically move from multiple group and individual therapy sessions to one or two individual group or therapy sessions weekly.

Knowing this information, it becomes clear that there is a discrepancy in how insurance companies cover care for a relapse by not covering/supporting clients adequately in the underlying issues that cause relapse after treatment. This gap in the treatment continuum for clients with an eating disorder is detrimental, and is what drove this study. It is essential for programs to be developed and researched for continuity of care purposes and lasting recovery, versus symptom reduction. Next, I define and propose the creative arts therapies as a possible modality to address this gap in treatment.

Creative Arts in Counseling: Drama Therapy

Expressive or creative arts therapies are used as umbrella terms for specific types of therapies, and are defined as the use of art, drama, dance/movement, poetry, storytelling, and/or music as a form of therapy (Gladding, 2005). For example, drama therapy and art therapy are both types of creative arts therapies. Each discipline has its own theoretical orientation and sets of tools. However, inherent in all creative arts therapies is the belief that creative expression can examine, explore, and discover what words cannot, and that the process of using the arts is inherently healing (Gladding, 2011).

Creative art therapies allow for fresh combinations of internal and external exploration of a client's world. Further, creative arts therapies provide a way for inner experiences to be expressed in nonverbal formats and to be externalized, allowing the

client to be seen and contained by the therapist in the creative art-making process.

Creative arts therapies provide a vehicle for those who struggle to access emotions and feelings to express themselves and, with containment and mirroring from the counselor, to gain more mastery over their feelings and experiences (Fleshman & Fryear, 1981).

One modality of creativity in counseling is the use of drama. Drama therapy is a type of creative arts therapy that is an action-oriented approach rooted in theatre, Gestalt therapy, psychodrama, and play therapy. Drama therapy is the intentional use of drama, theater, and its processes to create healing and therapeutic change (Landy, 1994). A registered drama therapist is a master's-level credential requiring coursework in psychology and drama therapy, experience in theater, supervised internship, and work experience. Registered drama therapists are board-certified in the practice of drama therapy and follow the North American Drama Therapy Association code of ethics.

Drama therapy operates on a few basic assumptions, which provided the groundwork for this research. In a grounding study, pioneer drama therapist Landy's (1993, 1994, 2008) seminal works are used to orient the reader to basic assumptions by which drama therapists operate. The first principal is that theater is inherently healing: "the ritual and healing aspect of theater performances have been demonstrated throughout history. The theater has been an institution for socially sanctioned emotional release, thought and recreation" (Landy, 1994, p. 49). Theater has a long history of providing catharsis, education, story, and ritual in aiding communities to come together and construct narrative. Theater eventually also evolved into movies and television, which also has continued to create a space where an audience suspends its disbelief to relate, learn from, empathize, despise, or escape its own pain through another character's

narrative. Therefore, the drama therapist understands the way theater has served throughout history and assumes that, by engaging in theatrical activities, there is therapeutic value.

Second is that the drama therapist understands theory of personality through the concept of role. “Human experience . . . can be conceptualized in terms of discrete patterns of behavior that suggest a particular way of thinking, feeling or acting. Role is the name for these patterns” (Landy, 1993, p. 67). From the beginning, we take on the roles or are given roles through consensus; for example, our earliest roles could include breather, sucker, mover, and child. Perhaps society has also deemed we are also a brother or a sister, or maybe an orphan. Later in life, we develop more complex roles through our actions in relationship to ourselves and to others. Each person has a number of roles they play or choose not to play. There may also be roles that we desire to obtain or let go of. In drama therapy, roles are a “unit of personality, a container of thoughts and feelings, a personality concept, a performed character in the theater and a metaphor for social life” (Landy, 1993, p. 8). A role is

an expression in behavior containing feelings, thoughts, and values associated with a single persona, rather than with a total personality. It is a part rather than whole, a single viewpoint of a view among others. Without role, there can be no story. A role can exist without a story, but requires story to communicate its essence. (Landy, 1993, p. 31)

That all is to say that, in drama therapy, the concept of a core self is eschewed. In this way, drama therapy can be housed within a postmodern social constructivist lens, wherein we can no longer have one knowable “truth,” but rather must “draw on the symbolic resources of our place and time in formulating viable theories or useful fictions that enable us to negotiate our social world” (Neimeyer, 1999, p. 23). A perfect example of this formation is how the exploration of role is executed by the drama therapist, which

is a process wherein the “client and therapist move in and out of fictional roles in order to lay claim to the best functioning everyday ones” (Landy, 1993, p. 30). How the drama therapist and client “move in and out” (Landy, 1993, p. 30) can be done in a number of different ways in drama therapy: through theater games, putting on a therapeutic theater play, improvisation, masks, and puppetry are just a few examples. However the drama therapist chooses to help a client examine role, the reason clients are

treated through drama, in part, because though their play and past dramatizations they have created a dysfunctional image of themselves in the world. In drama therapy, they re-create that image so that it can be reviewed, recognized, and integrated, allowing a more functional identity to emerge. (Landy, 1993, p. 48)

Finally, there are a number of tools and techniques that support the unfolding of this theory. An exhaustive review of drama therapy techniques is not relevant to this study, but there are two concepts that help further flesh out the theory for the reader. Those concepts include the tool of distancing and disowning the role. Distancing is “three feeling states: under distanced, over distanced and aesthetic distance. Each can be translated into a role that well embodies the degree of affect” (Landy, 1993, p. 148) and where the drama therapist uses the role to allow the client to both own the role and disown the role. This “me/not-me” paradox is the liminal space in which clients can begin to “construct an internal system of roles that translates into meaningful action in the world” (Landy, 1993, p. 31).

For example, perhaps a client is struggling to take ownership over his or her anger (by distancing from the feeling of anger). The drama therapist could help the client create a fictional, metaphorical role that he or she could invoke and name to explore those disowned feelings. For example, we could say the client calls this character Miss Fire Pants. Perhaps she starts off playing Miss Fire Pants and is doing well with exploring it,

both moving between that the role is her and not her and using metaphor and play and story to embody those feelings. But maybe, at some point, the play becomes too overwhelming, she becomes under-distanced and can not tolerate how close the feelings are, the boundary of Miss Fire Pants feels too close to being her and she shuts down. Here, the drama therapist can add more distance by perhaps allowing the client to wear an angry mask when she plays Miss Fire Pants.

Perhaps that approach is even too overwhelming, wherein a puppet could be used to create more distance and play Miss Fire Pants. Perhaps even that approach is too much and the drama therapist himself or herself can take on the role and the client can witness someone else play it. Thus, distancing allows the client to continue with the exploration at hand, but continues to make it safe to be explored. If, at any point, it becomes too overwhelming, the client can remove himself or herself from the role, for the moment saying, "I am not Miss Fire Pants, I am Sally." Eventually, through the continuation of invoking roles, naming roles, playing out and working through roles, exploring alternative qualities in roles, understanding counter-roles, and reflecting upon the role play, the client can then begin to relate the fictional role to everyday life, with the goal of "the ability to live with role ambivalence without undue stress and to discover new possibilities of being with oneself and others" (Landy, 1993, p. 54). All of these principals are important to understand in regard to this study because they are directly used in a type of drama therapy intervention called *therapeutic theater*.

Therapeutic Theater

Therapeutic theater is the intentional use of the process and performance of a theatrical piece with specific therapeutic goals and intentions in mind for the identified

population, using the previously described theory of drama therapy in combination with specific drama therapy techniques (Snow, 2000). Therapeutic theater is facilitated by a counselor skilled in drama and creativity in counseling or by a drama therapist. The culminating performance brings in an audience drawn from both in and outside of the participant's normal social sphere. Throughout rehearsals and post-performance, participants process the experience as applicable to the identified goals (Snow et al., 2003).

The Co-Active Therapeutic Theater Model

This study specifically used a new model for therapeutic theater called co-active therapeutic theater (Mowers & Wood, 2014). Co-active therapeutic theater was designed to offer the field of drama therapy a framework and theory for using therapeutic theater with populations who are in important role transitions in their lives. Co-active therapeutic theater is a six-phase model that allows the drama therapist to co-actively partner with participants in the development and execution of a theatrical production with the goal of helping clients move out of the role of "sick one" (Landy, 1994) and into strength-based role of directors and actors of their stories and lives. The model draws from Landy's (1994) role theory and method in drama therapy and Whitworth, Kimsey-House, Kimsey-House, and Sandhal's (2011) strength-based life coaching. The model is well suited for populations such as persons in recovery from an eating disorder or drug and/or alcohol addiction, exiting an abusive relationship, changing religions or spirituality, entering into a new developmental phase of life (e.g., parenthood or aging), or exiting from an old role that is holding a person back, such as being a victim of trauma (Mowers & Wood, 2014).

The six phases can be adjusted over various periods of time, depending on each

population's unique needs. For this study, the co-active therapeutic theater model was used over a period of 7 weeks, meeting twice a week for two 3-hour sessions and culminating in a public performance. The phases are

1. **Discovery:** the group comes together around a theme and identifies a topic regarding recovery that they want to explore and communicate to the community at large. In regard to this study, the participants gathered around the topic of recovery from an eating disorder and specifically wanted to explore the difficulties of engaging in the world as a human being, rather than a disconnected person who uses an eating disorder to cope and avoid feelings and vulnerability.
2. **Generation:** the group, co-actively with the drama therapist, engages in a series of theatrical improvisation games, drama therapy exercises using metaphor and role, and journal writing exercises to explore the selected topic in depth. From these exercises, a theatrical script is created. See appendix for final script.
3. **The weekend intensive:** during the weekend intensive, clients begin to explore the characters that they will be playing and explore how the character relates to or is different from roles they are experiencing in their own life and recovery process. The weekend intensive is also a time for acting skills training and empowering clients to authentically relate and connect on and off the stage with one another. The rehearsal process becomes a microcosm of the macrocosm.
4. **The rehearsal process:** the participants rehearse the play, moving between building acting skills and using drama therapy exercises to help them continue in the discovery process of their chosen topic. The drama therapist partners the clients as equals to achieve this goal. Both therapist and client are equally responsible for the process and production. An emphasis on process, empowerment, and growth is central in this phase.
5. **The performance:** co-active therapeutic theater must culminate in a performance that includes an audience. The play provides an opportunity for participants to take a risk, be vulnerable, and offer value to their community. The play ends with a drama therapy exercise designed by the cast to help the audience reflect on the performance. In the same way in which the drama therapist and participants are co-active, the participants become co-active with the audience.
6. **Integration:** in the final phase, the group processes and reflects on what they gained from the process and from their journey, and sets goals and intentions for carrying those lessons beyond the boundaries of the stage.

There are no actual phase models for therapeutic theater, but rather general guidelines (Snow et al., 2003). This model makes co-active therapeutic theater a potentially unique framework that could help clients in transition better embody new roles and reintegrate into their communities at large.

Qualitative Research

Qualitative research is conducted to discover “how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (Merriam, 2009, p. 5). Applied qualitative research is “undertaken to improve the quality of practice of a particular discipline” (Merriam, 2009, p. 3). More specifically, applied research can either be evaluative or action-based. This study was in line with evaluation research because the aim was to “collect data or evidence on the worth or value of a program, process or technique” (Merriam, 2009, p. 4). Research methods are discussed in depth in Chapter 3.

Research Questions

The need for treatment options during the first year of recovery from an eating disorder after intensive treatment is essential and is further evidenced by the literature reviewed in Chapter 2. The purpose of this qualitative research was to explore clients’ experiences of being a part of an experimental therapeutic theater project after intensive treatment for an eating disorder and examined how experimental therapeutic theater benefited or did not benefit their recovery process. The general research question was, “In what ways can therapeutic theater support clients in their first year after discharge from intensive treatment for an eating disorder?” More specifically, the question was, “How is therapeutic theater beneficial to participants in recovery from an eating disorder

treatment, and how is the co-active therapeutic theater process different than traditional group talk therapy in aiding clients after discharge from intensive treatment for an eating disorder?”

As noted, Chapter 2 includes a review of literature relevant to this study. First, literatures detailing relapse rates and struggles of recovery after intensive treatment from an eating disorder are presented to make clear the necessity of this research. This topic is followed by a comprehensive review of literature regarding current treatment models available/recommended after discharge from intensive treatment for an eating disorder, so the reader can understand what is currently available, as well as what is lacking. Next, I present relevant research on the use of drama therapy with clients with eating disorders as well as a review of research that has been conducted specifically with therapeutic theater.

In Chapter 3, I discuss my research site, participants, and the recruitment process for the Recovery Through Performance group, as well as the recruitment for this research study. Then, I expound upon my research methodology: a basic qualitative study for which I used grounded theory methods to analyze the data. For this study, data collection took place after the culminating performance and final group process meeting. Data were collected through demographic interviews, semi-structured interviews, and participants' journal entries that were completed during the course of the project. An overview of the data analysis process is provided in this chapter.

In Chapter 4, I present the findings of the data analysis, which yielded four categories that encapsulate the benefits participants received from the project, as well as a discussion of the difference between talk psychotherapy and therapeutic theater. Chapter

5 is the conclusion of the research report and includes a discussion on the findings, relates the findings to the literature, and proposes future directions for additional studies.

CHAPTER 2: LITERATURE REVIEW

This chapter represents a review of quantitative and qualitative research literature into adult eating disorder relapse rates, causes of relapse, factors pertaining to successful recovery, and evaluation of aftercare treatment programs as a means of helping the reader understand the need for development and study of interventions for clients working towards recovery from an eating disorder. Additionally, the benefits of creativity in counseling, drama therapy in the treatment of eating disorders, and relevant studies regarding the use of therapeutic theater are presented.

Relapse and Recovery

It is noteworthy that the literature on the treatment of eating disorders is vast. However, when it comes to research-based literature regarding recovery, relapse, and relapse prevention for adults with eating disorders after hospital-level care, the quantity of information is considerably smaller. Equally challenging is that much of the literature concerning relapse prevention addresses addictions pertaining to substance use, which primarily examines and evaluates interventions that focus on abstinence. Abstinence of course, is problematic when the addiction is food, from which living beings cannot abstain. Moreover, a cognitive differentiation between eating disorders and substance abuse has been highlighted in recent research, suggesting that eating disorder addictions have different neural pathways for their development than drugs and alcohol (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). As noted in Chapter 1, another primary issue in studying relapse and prevention is that the eating disorder community cannot come to

consensus in definitions of relapse and recovery, creating complications for conducting research successfully (Noordenbos, 2011).

In reviewing numerous seminal texts on eating disorders (Costin, 2007; Fairburn & Harrison, 2003; Gilbert, Shaw, & Notar, 2000; Harper-Giuffre & MacKenzie, 1992; Natenshon, 2009), the majority of books address the causes of eating disorders and hospital-based treatment. Sometimes, a brief chapter at the end of the book addresses relapse and prevention, but lacks empirical evidence. More common are books or workbooks dedicated to recovery, written anecdotally from the perspective of those who are in recovery from an eating disorder (Feigenbaum, 2009; Schaefer; 2003, 2009) or clinicians who have worked with eating disorders (Liu, 2011; Poppink, 2011). More promising information was available from articles, which are further discussed later in this chapter. However, most studies continue to emphasize that relapse “is a significant issue . . . and warrants both empirical and clinical attention” (McFarlane et al., 2008, p. 587).

Rates of Relapse and Remission

A recent publication by Keel and Brown (2010) provided a comprehensive review of 26 articles published from 2004 to 2009 regarding remission rates. For AN, follow-up studies range from 2.5 years to 18 years, with “remission rates varying considerably across studies” (Keel & Brown, 2010, p. 196). Within the shorter studies (2.5 years to 7 years), remission rates averaged approximately 29% (Keel & Brown, 2010). In lengthier follow-up studies (between 8 and 16 years), remission rates jumped to 68 to 84%. For BN, remission rates after the first year of treatment ranged from 27% to 28% and “increase as duration of follow-up increases (up to 70% or more by 1-year follow-up)”

(Keel & Brown, 2010, p. 196). For binge eating disorder, in four different 1-year follow-up studies, remission ranged from 25% to 80%. Keel and Brown (2010) noted that their results are “largely consistent with findings from previous comprehensive reviews” (p. 202).

In Keel and Brown’s (2010) meta-analysis of 26 studies, the sentiment remained consistent: “Anorexia nervosa and bulimia nervosa are chronic and relapsing conditions. Success rates of current treatments are far from satisfactory” (Richard, Bauer, & Kordy, 2005, p. 186). One study since Keel and Brown’s research also reported similar rates as previously mentioned for bulimia nervosa. In 2012, a 6-year follow-up study on relapse rates by Wilson et al. (2007) showed that “post-remission relapse was 46% for bulimia nervosa” (p. 190). It is also important to note that these remission and relapse rate studies vary on type and duration of treatment. Studies prior to 2004 were not included in an effort to provide the most current statistics regarding relapse and remission.

Longest Time Until Relapse After Intensive Treatment

A review of literature regarding the highest time for relapse for clients after intensive eating disorder treatment provided somewhat consistent findings, ranging from 3 months to 1 year. Olmsted, Kaplan, and Rockert (1994) reported that most clients relapse in their first 6 months after intensive eating disorder treatment. Woodside et al. (1998) reported that 3–6 months is the highest period for relapse. Carter, Blackmore, Sutandar-Pinnock, and Woodside (2004) stated, for anorexia nervosa, between 3 and 16 months is the most sensitive time period for relapse. Richard et al. (2005) stated the highest time for relapse is the first 9 months. McFarlane et al. (2008) reported that the first 12 months are the highest time of relapse. Carter et al. (2012) identified 4–9 months

as the most dangerous period for relapse. As revealed, in general, the first year after hospitalization treatment for all types of eating disorders puts the client at risk, and thus was used as the guiding point for this study.

Causes of Relapse and Factors that Determine Recovery

Repeatedly, recovery has been qualified as an elusive process. Starting in the 1990s, a few studies were published (Jarman & Walsh, 1999; Kearney, 1999; Peters & Fallon, 1994; Rorty, Yager, & Rossotto, 1993) and identified the need to better understand what factors determine recovery for persons with an eating disorder. Subsequently, a number of studies were conducted in the 2000s that have worked to capitalize on the unique perspectives that qualitative research can provide to help understand the complexities of the recovery process.

Pettersen and Rosenvinge (2002) conducted a mixed methods study that examined recovery from the patients' perspectives. Forty-eight women, ages 20–38, were interviewed. One key component in the study included identifying seven aspects at the core of the recovery process. These included accepting oneself and one's body; not relying on food and the eating disorder as a means of coping with issues or life stressors; discovering a purpose for one's life; learning to understand emotions and healthy expression of emotions; the ability to decrease anxiety and depression; finding meaningful ways to fulfill individual potential, including not living for others; and learning to cultivate and create good social functioning.

Tozzi, Sullivan, Fear, McKenzie, and Bulik (2003) noted "because there is no universally effective treatment for AN it is useful to investigate which therapeutic and life experiences play the most important roles in the outcome from the perspective of the

patients” (p. 150). In their investigation, they conducted interviews with 69 women with anorexia nervosa. Regarding recovery, three primary themes were identified by patients in the recovery process: supportive non-familial relationships, therapy, and maturation. The authors specifically note that clinicians should consider the importance of building interpersonal relationships as part of the recovery treatment planning.

Keski-Rahkonen and Tozzi (2005) examined a Finnish Internet chat group for 3 months and explored concepts around recovery. The researchers reported that participants identified concepts of willpower, motivation, and moving away from having an enmeshed identity with an eating disorder as essential steps that had to be taken to promote recovery. A grounded theory study conducted by Lamoureux and Bottorff (2005) continued to increase the body of knowledge regarding factors that are necessary in the process of recovery. They discovered five areas that were noted by nine patients, ages 19–48, who self-identified as recovered from anorexia nervosa. The categories Lamoureux and Bottorff (2005) reported included “seeing the dangers . . . inching out of anorexia . . . tolerating exposure without anorexia . . . gaining perspective by changing the anorexia mindset . . . [and] discovering and reclaiming self as good enough” (p. 180).

As Lamoureux and Bottorff (2005) explained, seeing the dangers involves persons in recovery having access to the psychoeducational components to the harm an eating disorder can cause. Inching out of anorexia involves the process of moving away from the power and control one experiences from an eating disorder and finding an identity outside of being a person with an eating disorder. Tolerating exposure without anorexia involves persons learning to cope in the world with stressful situations or major life decisions without relying on their eating disorder. Gaining perspective by changing

the anorexia mindset involves identifying the difference between an eating disorder voice and one's authentic self. Discovering and reclaiming self as good enough includes challenging perfectionism, discovering one's wants and needs, and building self-confidence in a community. All of these matters could be summed up in the core category of "becoming the real me" (Lamoureux & Botorff, 2005, p. 183) as the essential process necessary for recovery. The authors conclude that "the process of recovery described in this study may provide a useful framework for helping women understand their own process of recovery, and introducing them to strategies that support their recovery effort" (Lamoureux & Botorff, 2005, p. 170).

Keel, Dorer, Franko, Jackson, and Herzog (2005) conducted interviews to explore triggers of relapse patterns. They suggested that body image disturbance and psychosocial issues are primary causes of relapse. Thus, after hospitalization, treatment interventions should target "teaching patients to cope effectively with psychosocial stressors and to accept their bodies may help prevent relapse into eating disorders" (Keel et al., 2005, p. 2268).

Björk and Ahlström (2008) conducted a phenomenological study in Sweden for 18–26 months following patients' enrollment in a hospital eating disorder treatment program to examine patients' perspective regarding factors that are necessary for recovery. A number of categories emerged. Among them were that persons in recovery must develop a relaxed relationship to food, including being able to eat a variety of foods and having a regular eating pattern, as well as being able to eat with others. They also found individuals with eating disorders must develop a healthy relationship to the body, which includes acceptance and cooperation with the body. Self-esteem and self-

acceptance must be fostered, which involves self-respect and thoughtfulness about one's life and actions. Patients also reported a person must learn to deal with emotions in a healthy manner and foster social interaction, including being able to create a social life and give importance to those relationships, but not too much importance that a person loses their concept of self. Finally, according to patients in Björk and Ahlström's study, patients must build listening skills with others and themselves.

Similar to other studies, Federici and Kaplan (2008) conducted a phenomenological study with 31 weight-restored persons who received treatment for anorexia nervosa. They identified six categories that captured the subjective experiences of qualities that lead to recovery from an eating disorder. The six themes included that persons in recovery needed to (a) experience an internal motivation for change, (b) develop an understanding that recovery is a work in progress, (c) cultivate the ability to develop supportive relationships, (d) learn how to tolerate negative emotions, and (e) have engaged in a satisfactory experience with their higher level of care treatment experiences.

Recent studies by Emanuelli, Waller, Jones-Chester, and Ostuzzi (2012) and Peterson et al. (2012) results were also similar to previous studies. Emanuelli et al. (2012) administered a checklist to 238 participants (both individuals with an eating disorder and clinicians treating eating disorders) and found that "recovery criteria fall into five underlying dimensions: psychological–emotional–social criteria, weight-controlling behaviors, non-life-threatening features, life-threatening consequences and evaluation of one's own appearance. Overall, sufferers and clinicians ranked the importance of these factors in the same way" (Emanuelli et al., 2012, p. 369). In Peterson et al. (2012), a

qualitative study, four primary struggles to be worked through in the later stages of recovery were identified: (a) realizing the negative consequences of having an eating disorder, (b) searching for alternative ways of coping with life other than the use of an eating disorder, (c) searching and constructing an identity and finding normalcy, and (d) working through and accepting the grief and loss that may have led to their eating disorder. It is important to note that these qualitative studies conducted over the last 25 years not only showed the continued similarities of different areas that need to be addressed as part of the recovery process, but also provided valuable information in an effort to support the construction of programs to meet the multitude of needs in the recovery process.

Treatments After Intensive Hospitalization for an Eating Disorder

Despite the previously mentioned studies, little research exists regarding effective post-hospitalization treatment options. Fairburn (2005) provided a comprehensive look at evidence-based treatment for AN (both during hospitalization and after), ultimately asking, “is evidence-based treatment of anorexia nervosa possible?” (p. 29) and concluding, “Barely. A disquieting conclusion given the seriousness of the disorder” (Fairburn, 2005, p. 29).

Two studies regarding post-hospitalization treatment for AN were revealed in a search for relevant literature: Pike, Walsh, Vitousek, Wilson, and Bauer (2003) and Russell, Szmukler, Dare, and Eisler (1987). Russell et al. (1987) compared two groups, one of which received family-based therapy for adults and the other group received supportive psychotherapy and found no statistically significant difference in outcomes. However, Pike et al.’s study achieved statistically significant results.

Pike et al. (2003) conducted the first empirical evaluation of cognitive behavioral treatment post-hospitalization. In this study, 33 patients following hospital treatment for an eating disorder were randomly assigned to either a cognitive behavior group or a nutritional counseling group for one year. Findings indicated

The group receiving nutritional counseling relapsed significantly earlier and at a higher rate than the group receiving cognitive behavior therapy (53% versus 22%). The overall treatment failure rate (relapse and dropping out combined) was significantly lower for cognitive behavior therapy (22%) than for nutritional counseling (73%). (Pike et al., 2003, p. 2046)

No studies were found addressing post-hospitalization programs for BN or binge eating disorder.

With the ubiquity of the Internet and accessibility of social media, it is no surprise that Internet-based aftercare programs have been considered as an option to fill the treatment gap. In general, studies have found that such programs provide some usefulness for persons in recovery and have average participation rates; however, lack of individualization and in-person connection were reported as problematic. Most researchers have concluded that Internet support is useful in the early stages of recovery and less useful in later stages of the process (Bauer, Wolf, Haug, & Kordy, 2011; Golkarammy, Bauer, Haug, Wolf, & Kordy, 2007; Gulec et al., 2011; Gulec et al., 2014; Robinson et al., 2006).

As revealed in the literature reviewed for this study, relapse rates for clients with an eating disorders are a serious issue, and few programs exist. Furthermore, very few of the programs designed to help clients with recovery and relapse prevention address the factors reported to cause relapse. In the next section of this literature review, creativity in counseling, and more specifically, drama therapy, as a viable means to treat eating disorders is explored.

Creativity in Counseling

Numerous researchers and experts in the field have recognized that talk psychotherapy alone is not sufficient (Gladding, 2005; Schore, 1994; Siegel & Bryson, 2012; van der Kolk, 2006; Weiner, 1999). According to Weiner, this insufficiency is explained as follows:

Primary experience, which exists apart from language, is described by language as a representation, or secondary experience. Language is that secondary experience created by verbalizing primary experiences. Verbal psychotherapy, then, is a procedure for the verbal processing of verbal descriptions of events. Language constructs its own reality rather than corresponding to it. (Weiner, 1999, p. 13)

In essence, because we do not experience events primarily in language, how and why would we try to work through those experiences with language alone? Bergman (2009) stated, “Much current research shows that it is right-brain to right-brain unconscious communication between the psychotherapist and client which causes lasting change in a client’s internal regulatory system” (p. 2). In fact, some theories postulate that our earliest experiences, including ones that occurred in preverbal stages of the developmental process, can only be accessed by nonverbal methods and that creativity in counseling and creative arts therapies offer a means for counselors to access such stages (Gladding, 2005).

In his text, *Counseling as an Art: The Creative Arts in Counseling*, Gladding (2005) explored the use of creativity in counseling. He argued that creative arts therapies are beneficial for several reasons. First, they foster connection to deep feelings, and integration of experiences that talking alone cannot. They promote discovery of new energy and processing experiences in a different way other than just verbal language, which can be helpful. Creative arts therapies provide focus and allow clients to see more

tangibly their progress and maintain their goals. These therapies establish a new sense of self and assist clients in experiencing themselves in a different atmosphere. They involve concreteness, which allows clients to conceptualize and duplicate beneficial activities. They also foster group experiences in a way that typical group therapy does not by building socialization, self-esteem, and rapport.

Gladding (2005) also concluded creative arts therapies are multicultural and have a rich history of healing in a variety of cultures, allowing clients to express themselves in a culturally meaningful way. Finally, they sensitize clients to untapped aspects of themselves and foster awareness and understanding of uniqueness and universality (Gladding, 2005). Furthermore, Körlin, Nybäck, and Goldberg (2000) noted that “an important feature of creative therapies is that imagery and artistic expressions are seen as metaphors or symbols of the individual’s inner situation— for example, memories of trauma, conflicts, deficits, and mythology according to psychodynamic or Jungian theory” (p. 333). As noted from the studies on elements needed to help individuals unfold their recovery process, it would seem that creative arts therapies offer a conduit for such a process.

Finally, the recognition that talking alone may not be enough can be seen in shifts throughout organizational paradigms. For example, in 2004, the American Counseling Association created a specific division, Association for Creativity in Counseling, to address such issues. Given this specificity, there is an increasing amount of attention and desire to research the efficacy of creative arts therapies (Ziff & Beamish, 2004).

Drama Therapy and Eating Disorders

It has been consistently and well documented in the eating disorder literature that clients with all types of eating disorders engage in patterns of rigidity and chaos as a means of interacting with the world (Cassin & von Ranson, 2005). Persons with eating disorders who are rigid (typically those with AN) cope by being overly controlling, perfectionistic, and disconnected from their emotions, causing a loss of spontaneity and identity. Persons with eating disorders who engage in patterns of chaos (typically those with BN and/or binge eating disorder) are chaotic, out of control, compulsive, emotionally overwhelmed, lack clear boundaries, and feel empathetic to the point of somatically feeling another's pain, and easily identify (and at times over-identify) with others. They often present emotionally as being needy and having limited emotion regulation. Most common, however, is that clients exhibit both of these sides and vacillate between operating out of rigidity and being over-distanced or overwhelmed and are under-distanced from their feelings and body (Wood, 2015).

Drama therapy fosters aesthetic distancing or dramatic distancing, which is said to occur when drama lends itself to creating an environment where “the past can be remembered with a degree of feeling that is not too overwhelming, where intense emotional expression can be tempered by cognitive reflection” (Landy, 2008, p. 101). As discussed in Chapter 1, this capacity is achieved through the use of role. In drama therapy, clients have the opportunity to

play roles . . . to get in and out of oneself and to master both that which is situated inside, the role taken, and outside, the objective world. The more competently one plays out one's roles, the more one will develop an ease in navigating the sometimes difficult boundaries between internal and external experience. (Landy, 1994, p. 40)

Thus, drama therapy interventions allow the dismissive and overly distanced client the ability to step safely out of his or her head and into a role that permits him or her to experience feelings. Clients can then begin to expand their role repertoires to see how else they might feel or be, with the ability to quickly step out of the role and let go of the fear that may arise around experiencing affect. The distance titrates the flow of feelings and provides a context for such feelings to be more manageable. Conversely, drama therapy helps the under-distanced client by helping to slow down the flood of emotions, which allows the client to take control and to see more clearly the boundaries between himself or herself and others (Wood, 2015).

It is also common for clients with eating disorders to have polarized experiences and to vacillate between two extremes (Costin, 2007). An example of a polarized experience for a client with an eating disorder is that he or she may both desperately want to be in recovery but also is really attached to his or her eating disorder and wants to keep it. The playspace in drama therapy creates a stage for both sides to be explored and gives the client tools to contain and regulate affect. In this process, the client moves between being the director and actor in the drama of his or her life, allowing himself or herself to discover and experience the distance between the extremes (Wood, 2015).

A number of articles and book chapters have been written on the intersection of drama therapy and eating disorders (Jacobse, 1994; Jennings, 1994; Pellicciari et al., 2013; Rothman-Sickler, 1999; Rubin, 2008; Wood & Schneider, 2014; Young, 1994). These writings, while each offering unique perspectives on the interplay between the treatment of eating disorders and drama therapy, also share a few common themes. The

first theme is that drama therapy works to address the very thing that clients' eating disorders keep them from: the body. This is perhaps best summarized as follows:

In anorexia nervosa and bulimia nervosa, patients tend to divide their body from their head: in other words, they do not consider themselves as a whole. . . . Dramatherapy does not support this division between head and body, but concentrates on the patient as a whole. (Jacobse, 1995, p. 126)

Second, most of these studies have suggested that treatment for clients with eating disorders should include facilitating an intervention for the clients to understand, claim, and integrate their internal and external worlds. Drama therapy is well positioned to help facilitate this process. As stated by Pellicciari et al. (2013),

Theater can play a specific and important function during the multi-disciplinary assessment of eating disorders. The drama workshop can assume the function as a frame for actions, emotions, and relationships, becoming a transitional area in which feelings may be understood and patterns of thought can be assimilated. (Pellicciari et al., 2013, p. 608)

In regard to the treatment of an eating disorder, the drama therapist understands that clients with eating disorders are essentially locked into their roles and often see or experience themselves as their eating disorders. Paradoxically, they do not want to be only seen as their eating disorders. This viewpoint allows the drama therapist to facilitate a process of helping the client explore how the role of the eating disorder came into being as well as to help the client to expand his or her role repertoire, diving into exploration "of both individual and social roles, body and self image" (Young, 1995, p. 20). An extensive search for literature revealed no current qualitative or quantitative studies exploring the use of drama therapy and the recovery stages after hospitalization for clients with eating disorders.

Therapeutic Theater

Therapeutic theater theory is rooted in the concept that drama and theater are inherently healing. Earliest documentation regarding the therapeutic value of theater dates back to Aristotle (Meisiek, 2004). Ancient Greek people gathered twice a year to watch plays (from comedies to tragedies) in which the human experience was encompassed through narrative, movement, masks, roles, story, and metaphor. The Greeks, through identifying with the protagonist of the play, came to know their own mortal flaws via the process of identification. In those moments of recognition, the audience laughed and cried, thus producing catharsis. These cathartic gatherings were some of the earliest beginnings of therapy (Landy, 1994).

As a precursor to drama therapy and therapeutic theater, psychodrama must be mentioned. Psychodrama, a form of group psychotherapy created by Moreno in 1932, (Moreno, 1980) used group participants to become actors in the actual life stories of one another. “By directing the protagonist in the enactment of personal scenes, Moreno sought to provide a catharsis for the protagonist and for other group members watching” (Brunner & Hix, 2015, p. 29). Moreno (1946) worked with a variety of different populations and communities, using psychodrama as a tool for healing. Psychodrama, still used today, is intended for closed groups in which there are no outside audience members. The focus is not on aesthetics or acting, but rather achieving catharsis to promote integration (Moreno, 1946). Influenced by Moreno’s groundbreaking work, drama therapy emerged. Drama therapy is the intentional use of drama, theater and its processes to create healing and therapeutic change (Landy, 1994).

In the 21st century, psychodramatists have continued to document successful treatment outcomes of the use of psychodrama in conjunction with other treatments for clients with eating disorders (Godart et al., 2004; Izydorczyk, 2011). This documentation has primarily been developed through case study narratives. Like drama therapy, in psychodrama, clients with eating disorders have benefitted from the modality because psychodrama offers the unique “opportunity to build a relationship with themselves and experience themselves as inhabiting their own bodies” (Levens, 1994, p. 174).

In the 1970s, a number of pioneering drama therapists began to examine the therapeutic value of rehearsing and performing a play for psychiatric patients. They noted that

a shift in one’s perception of one’s self can be actualized through the performance which almost always carries in its process the sense of a rite of passage. Fears must be overcome, obstacles surmounted, and the threshold towards a new self concept, potentially crossed. (Snow, 2000, p. 236)

This examination led to a number of important considerations in their writings, as discussed below.

Johnson and Munich (1975) wrote about the process of using improvisation to create, rehearse, and perform a play with highly acute psychiatric populations, with the therapeutic intention of increasing hospital and community contact. The first of three plays were performed in the hospital setting, and the third outside of the hospital in the community. Johnson and Munich (1975) reported that the experience “was well received and gave the cast a sense of achievement and increased self-esteem” (p. 435).

Rose (1982) published a mixed methods study on producing a play using a well-known script with 28 chronic psychiatric patients and staff. Rose reported that, through the therapeutic rehearsal process, role-playing, and the performance with an audience,

“motivation, responsibility, and self concept” (p. 1018) all improved. Additionally, the project provided normalization and improved relationships between patients and staff involved in the project.

Soon thereafter, other drama therapists continued to examine the process of rehearsal and performance as therapy (Emunah, 1994; Landy, 1994, 1996, Snow 2000; Snow et al., 2003). Snow (2000), from reviewing other pioneers’ work, outlined four important prerequisites for the process of therapeutic theater to maximize the benefit for clients. These prerequisites included (a) “the client’s therapeutic needs must be placed first and foremost before aesthetic or entertainment values,” (b) “all roles must be appropriate for the physical, psychological and emotional needs of the clients involved,” (c) “improvisationally developed and self-revelatory performances hold the most value,” and (d) “support groups must be in place during and after the performance experience” (Snow, 2000, p. 230).

Perhaps most promising in relation to this study was an article in *Psychiatric Services* in which the power and potential for “theater to promote individual recovery and social change” (Faigin & Stein, 2010, p. 306) was directly addressed. Faigin and Stein (2010) noted that theater provides a space in which the stigma around mental illness can be addressed and persons with mental illness are provided with a role that has value in society. The authors urged researchers to conduct quantitative and qualitative research focused on therapeutic theaters’ capacity to address building a “sense of self, community integration, and quality of life” (Faigin & Stein, 2010, p. 308) in the individual recovery process and the impact in relation to the community at large.

Conclusion

Chapter 2 highlighted that relapse rates for clients with eating disorders has long been a serious and troublesome issue. Researchers have urged for program development and research to address the issue of eating disorder relapse with this challenging and complex population. As noted, creativity in counseling, and more specifically, drama therapy, has the capacity to potentially target many areas that cause relapse from an eating disorder. Furthermore, the literature review revealed that there are guideposts for therapeutic theater, but no defined model that could help better support treatment interventions, and therefore research.

As mentioned in Chapter 1, this study aimed to use this well-documented information in addition to this researchers personal experiences to provide another potential form of relapse prevention treatment: therapeutic theater. Chapter 3 details the research methods that were used to help examine how therapeutic theater might offer a means for supporting clients in recovery from an eating disorder.

CHAPTER 3:

METHODS

Research Design

The purpose of this research was to understand in what ways therapeutic theater might support clients after intensive treatment from an eating disorder. The design for this study was informed by the following research questions: “In what ways can therapeutic theater support clients in their first year after discharge from intensive treatment for an eating disorder?” “How is therapeutic theater beneficial to participants in recovery from an eating disorder treatment?” and “How is the co-active therapeutic theater process different than traditional group talk therapy in aiding clients after discharge from intensive treatment for an eating disorder?”

This chapter will detail the methodology chosen; explain the recruitment process, data collection, data analysis and specific procedures used within each area, as evidenced by the literature.

Because the goal of this research was to understand clients’ unique struggles after discharge from intensive eating disorder treatment and, more specifically, how therapeutic theater supported their recovery process, a basic qualitative, exploratory design was implemented. Qualitative research is “any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification” (Strauss & Corbin, 1990, p. 17). As Merriam (2009) described, qualitative research is aimed to understand “how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5). More specifically, underlying basic qualitative research is the constructivist belief that

“individuals construct reality in interaction with their social worlds” (Merriam, 2009 p. 22). Therefore, a basic qualitative study would specifically be interested in “(1) how people interpret their experiences, (2) how they construct their worlds, (3), what meaning they attribute to their experiences” (Merriam, 2009 p. 23) and would not have an additional dimension, such as a phenomenological, ethnographic, grounded theory, or narrative analysis lens (Merriam, 2009).

While a grounded theory approach to data analysis was utilized, this researcher’s intention was not to build an original theory. As Saldaña (2013) noted, “original theory development . . . is not always necessary in a qualitative study. . . . Research that applies pre-existing theories in different contexts or social circumstances, or elaborates or modifies earlier theories can be just as substantive” (Saldaña, 2013, p. 224).

In this study, both the literature review and a previous pilot of the project helped to shape the research design. The nature of this project was in response to the literature findings that reported clients were at their highest risk for relapse in the first year after intensive treatment (McFarlane et al., 2008) as well as the researcher’s personal observations. Because the literature review, in part, drove the study, a grounded theory approach was ruled out; grounded theory aims to create a theory that “does not come off the shelf, but rather is generated or grounded in the data from participants who have experienced the process” (Creswell, 2007, p. 63). Rather, the core of the study rested in understanding the interplay between eating disorder recovery and the use of therapeutic theater as a means of supporting clients during the highest reported time of relapse following intensive treatment. Also noteworthy is that this basic qualitative study operated under a constructivist lens, meaning:

What is known derives from social interaction within cultural contexts. Knowledge does not come from objective characteristics of the thing to be known. Nor does knowledge reside in individuals. Knowledge is social and a result of shared perceptual experience and communication about those experiences. Postmodernism places all truth seeking within its historical, cultural, and bio-social context. In other words, truths derive from the process of consensualizing, a process of defining what is known through social interaction about shared experience. (Cottone, 2012, pp. 89–90)

This lens was important because the researcher looked to comprehend the shared understanding that people experience as related to how therapeutic theater might fill the gap in the treatment continuum. The study did not aim to prove or disprove if therapeutic theater supports clients in the treatment continuum; rather it attempted to understand in what ways it benefitted persons on their eating disorder recovery journey.

Site

Recovery Through Performance was founded by me, Laura Wood, in 2014 and had its first performance on November 7, 2014. Recovery Through Performance is currently in process with a pro-bono lawyer for support in obtaining 501(c) status. The Recovery Through Performance vision statement is, “Through the use of therapeutic theater, individuals in the process of recovery from an eating disorder or other addictions can explore unsafe ideas in a safe (play)space.” The Recovery Through Performance mission statement is, “To serve persons on their recovery journey through theater and drama therapy, helping them transform into being the actors and directors of their own authentic lives.” Recovery Through Performance relies on donated or reduced-fee space for its rehearsal and performance process.

For this run of the project, rehearsal space was secured at a local office building in Sunset Hills, Missouri. The theater space was secured at The Gaslight Theater in Saint Louis, Missouri, and paid for by a grant from The Drama Therapy Fund. Again, it was

important to the ethics of this study to note, in Chapter 1, the section on the researcher's perspective in choosing this site. Because it was a company that I created, it was important for the readers to be aware of my inherent bias in selecting a site to which I had access and a personal curiosity in researching.

Sampling Methods

Purposeful Sampling

Coyne (1997) suggested that the quality of a research study is dependent upon the process through which the sample is selected. For this study, purposeful sampling was used. Through this type of sampling, the researcher purposefully selects “information-rich cases” (Coyne, 1997, p. 627) that meet certain criteria based on the research question (Merriam, 2008). As Merriam (2008) explained, “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry” (p. 77). There are a number of different types of purposeful sampling. For this study, a typical sample was used. Typical sampling is used to represent the average types of people that would represent the spectrum of persons in first-year stages of recovery (Merriam, 2008).

Recruitment and Selection Criteria

It is important to note that the recruitment for the project itself was separate from the recruitment for the research study. Recruitment for Recovery Through Performance took place via the company website. Additionally, two local eating disorder treatment centers—Castlewood Treatment Centers for Eating Disorders and St. Louis Behavioral Health—were contacted and asked to distribute information to their local alumni. Local outpatient therapists specializing in eating disorders also received information regarding

the Recovery Through Performance project recruitment. Participation in Recovery Through Performance was contingent on several criteria. First, the participant had to self-identify as having an eating disorder. Second, the participant was in individual therapy, at least once weekly, during the duration of the project. Third, the participant had and provided a letter of approval from his or her individual therapist approving participation. Fourth, the participant had to be at a minimum of 88% of ideal body weight, as confirmed by his or her outpatient treatment team in the approval letter. Fifth, the participant had to commit to the weekend intensive project and agree to miss not more than one rehearsal, unless due to an unforeseen circumstance. Sixth, the participant agreed to sign in at the beginning of each rehearsal, stating he or she was currently safe and had no plan of self-harm and was not actively suicidal. Seventh, the participant was not currently in any level of intensive care for an eating disorder. *Intensive care* was defined for the purposes of this study as inpatient hospitalization, residential treatment, partial hospitalization, or intensive outpatient care.

Recruitment for Recovery Through Performance and the recruitment of participants for the study were separate processes. Someone could have participated in the Recovery Through Performance project but not qualified for this research study. This distinction is important to note because this research was driven through the socially just act of providing services for anyone in recovery for an eating disorder who met the project criteria, not just the research criteria.

I explained to participants before signing on to be a part of the Recovery Through Performance project that they would be invited to participate in my dissertation research at the culmination of the project if they met the specific study criteria. They were

informed that if they granted me permission, the journal assignments (which all members of the company completed over the course of the rehearsal process) would be requested, and that they would be requested to participate in a follow-up interview that would be tape-recorded.

Selection for the research study included all of the above criteria for participation in the Recovery Through Performance project, with two additional criteria. First, eligible participants must have completed some level of intensive care for an eating disorder. Second, participants must not have been more than 1 year after intensive care at the start of the project. I hoped to recruit six to eight participants for the research study.

Confidentiality

Due to the nature of the Recovery Through Performance project, which included a culminating public performance, issues of confidentiality were unique. At the information meeting before the start of the Recovery Through Performance project, I explained to potential project participants that the rehearsal process and performance would involve exploring recovery from an eating disorder with other group participants, as well as sharing the final work with a public audience. Potential participants were asked to explore the implications of admitting to struggling with an eating disorder with both people they might not know in the project as well as with a public audience. Additionally, potential participants who had received treatment from this researcher at the treatment center where I worked were asked to explore questions or concerns regarding their privacy. This concern was because I am a well-known therapist at Castlewood Treatment Center and audience members could make an assumption that the participants in the

project were clients of mine, therefore making an aspect of their health care privacy more vulnerable.

Regarding the research portion of the project, participants were made aware that their journal entries would be read and coded by this researcher, as well as the research assistant and others involved in the data analysis. Consent forms were written in simple, plain language. Consent forms were verbally explained, and participants were given time to read and ask any questions. Because the final interviews were transcribed professionally, each audio recording was assigned a number, and names and identifying information were removed. Interviews, demographic surveys, and recordings were stored in a locked box. All data were stored on a password-protected computer in a locked office. Voice-recorded data will be destroyed 1 year after the completion of the final manuscript associated with this research. Finally, participants were made aware that, at any point in the research portion of the project, they could withdraw from the research portion of the project, without penalty. Participants were also informed that, for the final manuscript, they could choose a pseudonym for themselves as an additional privacy measure to allow for dissemination of the research.

Participants

There were seven participants in this research study: six women and one man, ranging in age from 23 to 33 years old. Each participant is described in this section, based on information from the demographic questionnaire, and any background information that helps to bring to light information discussed in their interviews.

Callie Kaiser. Callie Kaiser was a 24-year-old who identified as a White, heterosexual woman. She was single and had never been married. She earned some

college credits before entering into treatment. At the time of the interview process, after the performance, she was gainfully employed part-time as well as attending college again. She identified her family as being from an upper middle-class socioeconomic background. She was in recovery from BN and binge eating disorder, and also had been diagnosed with clinical anxiety and depression. At the start of the project, she had been discharged from treatment for approximately three months. Before the start of the project, she had been in higher levels of eating disorder care on three separate occasions. Callie had lost her mother to cancer when Callie was a young teenager, and often the unresolved feelings from this relationship were present in the current manifestation of her eating disorder. Coming into the project, she had no acting experience.

Sidney Bella. Sidney Bella was a 32-year-old who identified as a White, heterosexual single woman. She had a bachelor's degree and grew up middle class, but then, when she was a teenager, her family became upper middle class. Previous to the project, she had been in treatment twice, once for 2 months and then for 9½ months. At the start of the project, she was 2½ months out of treatment and was struggling. She was diagnosed with BN and AN and orthorexia, as well as bipolar disorder and post-traumatic stress disorder. At the time of the interview, she was in outpatient treatment and employed part-time.

Raj Mateo. Raj was a 33-year-old who identified as an Asian man. He was divorced and had earned his bachelor's degree. He was raised upper middle class and diagnosed with binge eating disorder, anxiety, depression, and post-traumatic stress disorder. At the time of his interview, he was self-employed and working on a men's clothing line for larger sized men, as inspired by his work in recovery. He was in

treatment once prior to the play and also was a member of the pilot project of Recovery Through Performance. At the start of the study, he was 11 months into his recovery.

Piper McGee. Piper was a 31-year old self-identified White woman. She was divorced and described her sexual orientation as pansexual. She grew up lower middle class and, at the time of the study, was receiving Social Security disability assistance. Coming into the project, she had earned some college credit. She was diagnosed with an eating disorder-not otherwise specified, dissociative identity disorder, post-traumatic stress disorder, and anxiety. She was 4 months out of treatment at the start of the project and had been in treatment 14 times. At the time of the interview, she had started college and was in outpatient treatment. Previous to the project, she had theater experience, but no therapeutic theater experience.

Victoria Smith. Victoria was a 25-year-old who self-identified as a White, single, heterosexual woman. At the time of the project, she was 1 month into recovery after intensive treatment. She had completed a bachelor's degree and was raised in an upper middle class family. She was diagnosed with BN, depression, and anxiety. She had a musical background, but through the course of her eating disorder, had lost passion in and connection to her musical abilities. At the time of the interview, she was enrolled in a master's program and in outpatient treatment.

Ellie Asher. Ellie was a 31-year-old single, White, heterosexual female. She had a master's degree in occupational therapy and, at the time of the interview, was self-employed and worked as a nanny with kids with special needs. She grew up lower middle class and was diagnosed with AN and major depressive disorder, generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and dissociative

identity disorder. Prior to the project, she had four admissions to residential eating disorder treatment.

Meghan Charn. Meghan declined to turn in her demographic form. From observation and personal contact in the project, she appeared to be a White woman who identified as a lesbian. She was in her late 20s and had been in eating disorder treatment multiple times. She was employed full time at a coffee shop and also babysat on the weekends.

Data Collection

There were two parts to the data collection process in this research study. The first was collecting the participants' journals after the performance. The second was individual semi-structured interviews, also at the end of the project.

Through the process of Recovery Through Performance, cast members were given journal prompts after each rehearsal to reflect on the process that occurred, specific to that day. The journal prompts were based on a general structure outlined by the co-active therapeutic theater model, as discussed in Chapter 2. Overall, the journal prompts aimed to create a space for clients to reflect on what was unfolding organically in the rehearsal process in relation to their recovery process. The journals also provided a basis for helping to create the final interview questions.

The semi-structured, in-depth interviews were the main form of data collection used in this study. Interviews provide a researcher with qualitative "detailed descriptions of people's activities, behaviors, and actions" (Patton, 2002, p. 4) as a means of helping the researcher understand the process being investigated. The semi-structured interview format was selected because it offers flexibility with some guidance and allows the

researcher “to respond to the situation at hand, to the emerging worldview of the respondent, and to new ideas on the topic” (Merriam, 2009, p. 90). Additionally, because clients with eating disorders can become easily overwhelmed, especially those new in recovery (Feigenbaum, 2012), semi-structured interviewing was selected to help give a framework and guide to the process.

One-on-one interviewing was selected over focus groups so participants could have an opportunity to speak freely versus potentially being in a focus interview, where aspects of old eating disorder mentality of competitiveness or perfectionism might be activated (Feigenbaum, 2012). As recommended by Smith and Osborn (2008), the protocol was structured so that impersonal questions were listed first, with more personal questions being listed last. The interviews were audio-recorded and planned to last between 1½ and 2 hours. There were two primary goals for the interviews in this study: (a) to obtain demographic data and (b) to explore the participants’ experiences and perceptions of life after intensive treatment and how therapeutic theater does support or does not support that process.

Interview Protocol

First, a written questionnaire was administered to collect demographic information. Questions addressed participant’s age, race, sexual orientation, economic status, type of eating disorder, amount of time after intensive treatment, and support systems outside of the Recovery Through Performance project. Second, the semi-structured interview was conducted. Interviews were set up in a local counseling office space to allow for participants to have privacy and comfort. Because the researcher was very close to this project, an outside researcher was brought in to conduct the interviews.

Questions were open-ended and used to elicit experience, opinions, values, feelings, and knowledge. Probing questions were used to help clarify and flesh out ideas from the participants (Merriam, 2009).

Notes and Transcripts

Brief written memos were used by the researcher conducting the interviews as a way of capturing participants' body language, energy, and unspoken subtext in the process of the interview. Recorded interviews were sent for professional transcription, with each line of text assigned a number. After the initial transcription, the researcher listened to each interview and read along with the transcribed interview, checking it against the audiotape for accuracy (McLellen, MacQueen, & Neidig, 2003).

Data Analysis

Data analysis was conducted utilizing grounded theory strategies of the constant comparative method, collaborative coding, open coding, and axial coding (Corbin & Strauss, 1990). Strauss and Corbin's (1998) seminal coding process and texts were used in this design because they provided more detailed language around the process of analysis than some of their more recent writings. Each process is described below.

Coding

Coding is "the process of analyzing the data" (Strauss & Corbin, 1998, p. 61). A code is most often a "word or short phrase that symbolically assigns a summative, salient, essence capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña, 2013, p. 3). Data are coded to "discern and label its content and meaning according to the needs of the inquiry" (Saldaña, 2013, p. 14). Specifically in this study, coding was done manually, meaning that no computer programs were used in the process

of analysis. This approach was specifically chosen because this researcher agrees with the sentiment shared by Saldaña (2013), that “manipulating qualitative data on paper and writing codes in pencil . . . gives you more control and ownership of the work” (p. 26). Given the highly personal nature of the project and study, abstaining from the use of a qualitative computer program seemed most appropriate.

Constant Comparison

Throughout the entire data analysis process, the data were continually questioned and compared for similarities and differences using the constant-comparative method (Corbin & Strauss, 1990; Strauss & Corbin, 1998). The constant comparative method helps the researcher to “flush out concepts and their relationships” (Corbin & Strauss, 1990, p. 66) and to “challenge the concepts with new data” (Corbin & Strauss, 1990, p. 9). Through comparing and contrasting conceptual labels, concepts were clustered by similarities, yielding the emergence of categories and subcategories.

In defining subcategories, the researcher analyzed the data while asking, “when, where, why, who, how, and with what consequences?” (Strauss & Corbin, 1998, p. 125). In keeping with the constant-comparative method, data were compared against and across levels (i.e., categories to categories, categories to subcategories, and so on) in order to ensure there was no crossover between or among them and that any biases had been penetrated.

Collaborative Coding

Collaborative coding is the process of working with other research team members to bring multiple perspectives to the process of analyzing and interpreting the data, with the goal of possibly generating “new and richer codes” (Saldaña, 2013, p. 34). In this

study, I was the primary researcher, but was fortunate to have a research assistant, Paula, for the project. At the time of the study, Paula was taking a qualitative research methods course for her master's degree in drama therapy and joined in as a first-cycle coder for the study as part of her course requirements. We separately open-coded each interview, and came together and compared, contrasted, and discussed findings. We then went back to solo open coding of the next interview and again reconvened to debate. These reconvening intervals were an opportunity for us to question our own and each other's assumptions about the phenomenon (Strauss & Corbin, 1990). In the next stages of axial and selective coding, I provided Paula with copies of my coded data for her to rigorously examine and audit. Additionally, I sporadically worked with a qualitative team that I have been a part of through the years in my doctoral studies; they served as additional voices in checking the process of analysis.

Open Coding

The first step in this data analysis was to engage in a process of first-cycle coding. "Initial" coding or open coding was selected. The process of open coding allows the researcher to break "down qualitative data into discrete parts, closely examining them and comparing them for similarities and differences" (Strauss & Corbin, 1998, p. 102). Open coding was the starting point to "provide the researcher with analytic leads for further exploration and to see the direction in which to take this study" (Saldaña, 2013, p. 101). Additionally, the open coding involved microanalysis, also referred to as "line-by-line coding" (Strauss & Corbin, 1998, p. 57). Microanalysis was selected for this research as a means of providing focus for the researcher. Microanalysis supports the researcher in being able to "listen closely to what the interviewees are saying and how they are saying

it” (Strauss & Corbin, 1990, p. 65). In the open coding, the primary focus was on process, which is defined as “participant actions that have antecedents, causes, consequences, and a sense of temporality” (Saldaña, 2013, p. 103). Open codes were marked in pencil on the transcribed interviews.

Axial Coding

Saldaña (2013) stated that second-cycle coding allows the researcher “advanced ways of reorganizing and reanalyzing the data coded through first cycle methods” (p. 207). In this study, axial coding was employed as a second-cycle method. Axial coding “describes a category’s properties and dimensions and explores how the categories and subcategories relate to each other” (Saldaña, 2013, p. 209). “Properties and dimensions are important to recognize and systematically develop because they form the basis for making relationships between categories and subcategories” (Strauss & Corbin, 1990, p. 69). Properties convey the attributes of a category, while dimensions indicate intensity along a continuum. Axial coding was also used to

determine which codes in the research are the dominant ones and which are the less important ones . . . [and to] reorganize the data set: synonyms are crossed out, redundant codes are removed and the best representative codes are selected. (Boeije, 2010, p. 109)

Axial coding is particularly useful when the study has “a wide variety of data forms” (Saldaña, 2013, p. 218) and was selected because this study utilized both journal entries and interviews. Through axial coding, categories and subcategories were linked with their properties and dimensions, thereby providing a richer understanding of the phenomenon.

Selective Coding

Selective coding was not utilized. Selective coding is the “process of selecting the core category, systemically relating it to other categories, validating those relationships,

and filling in categories that need further refinement and development” (Strauss & Corbin, 1990, p. 116). In selective coding the core category would be aimed to group all of the products of analysis into a few words that explain the heart of the research (Saldaña, 2013). In this study, though a theory was not being built, the core category would be aimed to synthesize the use of therapeutic theater for persons in the recovery process from an eating disorder in response to the problem posed in the literature regarding recidivism following intensive treatment. At the conclusion of this study, saturation was not reached, and therefore, no core category could be determined. However, I am happy to share that this research has received funding for 2016-2017 and will continue to work towards building a core category.

Analytic Memos

Analytic memo writing is used to “document and reflect on [the] coding process and code choices; how the process of inquiry is taking shape; and the emergent patterns, categories and sub categories, themes, and concepts in [the] data” (Saldaña, 2013, p. 41). Analytic memos were each categorized according to their primary purpose (e.g., a code note memo, research question memo, task memo, or axial memo [Saldaña, 2013]). Each memo was dated to track the evolution of the analysis process. The researcher used Saldaña’s (2013) guide point on writing analytic memos in that, anytime significant ideas or discoveries occurred in the process of analysis, the researcher stopped and recorded that information. The process of coding and writing analytic memos was a cyclical process that was also used to further discover codes and categories “embedded within the analytic memos” (Saldaña, 2013, p. 51).

Trustworthiness

Despite the fact that this study operated through a constructivist lens of multiple ways of understanding shared experiences, it was still essential that tactics for testing and confirming findings were rigorously in place. In this study, confirmability, credibility, transferability, and documentation were considered in regard to building a more trustworthy study (Miles & Huberman, 1994).

Confirmability

Miles and Huberman (1994) summed up confirmability as the researcher having “relative neutrality and reasonable freedom from unacknowledged researcher biases—at the minimum, explicitness about the inevitable biases that exist” (p. 278). They went on to suggest a number of queries that researchers can build into the process of their research to strengthen confirmability. The first suggestion was for the researcher to explicitly describe the methods and procedures in detail, thereby allowing readers to track the sequence in which the study was executed and followed a clear “audit trail.” This chapter attempts to address that concept by making accessible the methods and procedure in detail. The second suggestion was that the researcher is “explicit and self-aware as possible about personal assumptions, values, and biases . . . and how they may have come into play during the study” (Miles & Huberman, 1994, p. 278). This suggestion was addressed both in the personal narrative in Chapter 1 and as further in-depth discussion that is included at the end of this chapter in Researcher Perspective. Finally, the researcher addressed “competing hypotheses” (Miles & Huberman, 1994, p. 278). This matter is addressed in the discussion section of this dissertation in Chapter 5.

Dependability

Dependability examines if the “process of the study is consistent, reasonably stable over time and across researchers and methods” (Miles & Huberman, 1994, p. 278). In addressing this matter, I worked to make my role in the project and my relationship to the site explicit to all participants. My research assistant and I worked with the same protocol during the coding process and we utilized coding checks. Additionally, our discussions were specifically noted in the memos.

Credibility

Credibility examines if the findings of the research study make sense and if they are “credible to the people we study and to our readers” (Miles & Huberman, 1994, p. 278). Following findings, this researcher used the process of member checks, in which participants from the research study were presented with the unfolding data and asked to consider if the results “rang true.” Member checks were also a time for participants to provide additional feedback. Eating disorder professionals, including an eating disorder specialist on this dissertation committee, were also consulted after data analysis regarding the findings and asked to provide further thoughts or questions. Finally, “areas of uncertainty” (Miles & Huberman, 1994, p. 279) were identified and explored in the discussion portion of this dissertation. Additionally, as previously discussed, by using an outside researcher to conduct the interviews, credibility was increased for the study.

Transferability and Application

Transferability offers another avenue of trustworthiness for a study. Transferability speaks to the ability of the research to “fit” in another context (Lincoln & Guba, 1985). One avenue of achieving transferability is by ensuring that data findings are

described in “thick description for readers to assess the potential transferability [and] appropriateness for their own settings” (Miles & Huberman, 1994, p. 279), which readers can take note of in Chapter 4. This study was aimed at making the process of therapeutic theater for eating disorder and addictions populations digestible and applicable in hopes that others could use parts or all of the process to apply to their own communities. This study also addressed application by attending a call for action by practitioners to “solve the local problem” (Miles & Huberman, 1994, p. 280) of recidivism in eating disorder recovery following intensive treatment (Woodside et al., 1998).

Triangulation

Finally, triangulation is a means of enhancing trustworthiness. One form of triangulation is the use of “multiple sources of data” (Merriam, 2009, p. 215). At the end of the study, the participants’ responses were collected from the journal entries and individual interviews were conducted in relation to what the literature had reported. Discrepancies or overlap were noted and are discussed in the Results in Chapter 4.

Researcher Perspective and Ethical Considerations

In an effort to enhance trustworthiness in the study, this section was aimed to transparently express my potential biases in regards to the Recovery Through Performance project and more importantly regarding this specific research study. To start, as the founder of the Recovery Through Performance project, I have been deeply invested in the mission and vision statement, and have been motivated to research the work I do. Moreover, as someone who spent a lifetime in the theater and pursued a Master of Arts degree specifically in drama therapy, it is safe to say that I am biased in my belief regarding the power of theater as a healing modality. Regardless, I attempted to

make sure that questions in the interview were structured to examine either the benefit or lack thereof in the project. For example, one question was, “How might or might not the rehearsal process in Recovery Through Performance have supported you on your eating disorder recovery journey?”

The process of the project could have been considered intimate, and some of the participants might have been familiar with me due to having received treatment for their eating disorder at my place of employment. Ongoing conversations took place regarding the difference between boundaries in a treatment center and boundaries in the therapeutic theater process. Before the start of the project, previous clients from the treatment center in which I worked were notified that being a part of the project naturally linked them to me and people were aware of my place of employment. Additionally, unlike treatment, there were no “therapy” check-ins and material that was not discussed in the group process should be brought to their individual therapists. However, if a specific struggle related to the project arose, people were aware that I was a resource for them after our meetings or via e-mail. Because the project culminated in a public performance, participants were reminded that they would openly and publically discuss that they were in recovery from an eating disorder.

Because I was, at the time of the study, and remain employed by an eating disorder treatment center, I was required to meet with my place of employment research privacy board to discuss ethics of the project. As part of their policy, I was not allowed to collect data during the process of the project, but could collect data after the culmination of the project. This process worked out well because it was in line with the social justice perspective of Recovery Through Performance, in that participation in the project did not

rely on meeting criteria for participation in the research. Additionally, participants were notified that the project would not be conducted in affiliation with the treatment center for which I worked. This notification was included in the consent form that research participants signed.

Also important to note was that people wanted to be a part of this project far before recruitment had even started. After the autumn production, there was an overwhelmingly positive response. Additionally, my positive reputation at the eating disorder treatment center where I work and within the Saint Louis eating disorder community lent to drawing people to the project who specifically wanted to work with me. This does not mean that they necessarily *liked* theater, but they admittedly liked something about working with me as a drama therapist. I addressed this distinction by explaining to participants that part of what was important about research was the goal of understanding their unique experiences and voices, not what they thought I wanted to hear. We had open discussions about how their honesty could help refine future projects and their feedback could contribute to helping others in recovery as the project evolved. In the pilot study, pilot participants were able to provide constructive feedback and genuine responses and it was hoped the study phase of the project would yield similar levels of input.

In review, a pilot study was first conducted as a means of assessing if the project seemed worthwhile in primarily benefiting persons in recovery from an eating disorder, rather than being driven by researcher priorities (Miles & Huberman, 1994). Both a qualitative research team of doctoral students and the treatment facility where I worked helped to shape and provide feedback to ensure the project was ethically sound.

Conversations were held with project participants regarding ethics, boundaries, and our relationship in the project. People could participate in the project even if they did not qualify for the study. Bracketing was used as a technique during the coding process to reduce the possibility of my biases, and potential biases were noted in memos. A research assistant was brought on to help offer another perspective, as well as a team of professors on my doctoral dissertation committee. Also, member checks were employed to enhance trustworthiness and were a number of checkpoint questions, as discussed previously in this chapter. Finally, this section was written to be an exhaustive, transparent, and detailed consideration of the researcher's effects that might have been present.

Limitations

This section will discuss structural methodological limitations and in chapter 5 actual limitations of the conducted study will further be examined. Some methodological limitations include researcher bias, which a detailed plan was constructed to help mitigate, as discussed in this chapter. Furthermore, as discussed, qualitative research can never claim an objective truth, but a number of techniques can be employed to “increase the credibility” (Merriam, 2006, p. 215). As such, confirmability, credibility, transferability and application were examined previously. Chapter 5 will also crystallize the data findings against current literature as discussed in chapter 2. Finally, as previously noted, this study was not able to reach saturation due to the small size of the project. Hopefully, future generations of the project will allow for a core category to be identified.

CHAPTER 4:

FINDINGS

The purpose of this basic qualitative study was to determine in what ways therapeutic theater could support clients in their first year following discharge from intensive treatment for eating disorders, and in what ways therapeutic theater could help to facilitate the process differently than traditional forms of talk psychotherapy. The participants of the study included seven people who were all within their first year of recovery after completing intensive eating disorder treatment. The participants' ages at the time of the study ranged from 25 to 35 years. There were six women and one man. All were residing in Saint Louis, Missouri, though some of the participants had moved to Saint Louis after treatment and were creating a new home in the city. In the first part of this chapter, the four categories that emerged regarding the benefits of the project are presented. In the second part of this chapter, unique aspects that differentiate theater from talk group therapy are examined.

Categories

Because I was so close to the project, a co-researcher was brought on board to conduct the interviews. The co-researcher did not see the play, therefore offering another level of objectivity. Four categories emerged that answered the main research question regarding how therapeutic theater could benefit clients with an eating disorder after intensive treatment: (a) providing containment, (b) fostering relationships, (c) practicing emotion regulation, and (d) advancing psychological recovery. In the following sections, each category and its subcategories are presented.

Category 1: Provides Continued Containment

Inpatient, residential, and partial treatment for clients with eating disorders offers considerable containment. *Containment* is a word that is commonly used in eating disorder treatment and can be defined as interventions that provide an appropriate level of structure for the client's life on a daily basis as well as supervising clients' eating disorder behaviors to aid in the recovery process. An example of structure in higher levels of care is group programming. An example of supervising eating disorder behaviors is observed meal support and bathroom monitoring. Interestingly, Category 1 mirrors what higher levels of care offer, but is tailored to where the clients are in their process. Two subcategories emerged in Category 1: structure and abstaining from eating disorder behaviors, both of which are examined below.

Continued containment specifically captures the way in which after intensive treatment is completed the continuation of containment is maintained by the following two subcategories.

Structure. Multiple times in the interview, five of the participants spoke to the way in which Recovery Through Performance provided structure to their lives after treatment. The dimension of responses ranged from participants speaking to the necessity of the structure to it being helpful in their recovery process.

In the interview, Piper described that she had graduated from the lowest level of eating disorder treatment and had the summer months off before she was scheduled to start her undergraduate studies at a local university, which she knew would help provide structure. She spoke to the necessity of the structure of Recovery Through Performance in regard to her recovery:

Well, I think it was really helpful. I kind of have this magical time to be in this play because I had just gotten out of step-down not too long before it and I would have had all summer to, like, kind of . . . I don't know what would have happened without this play! But to have something to contain me, before school starting, because I was spinning out, like, fearing school. So it was really helpful to have this structured community that I would go to. (Piper, lines 191–198)

Here, we see the necessity of both containment and, specifically, how structure helps provide continued containment within a set schedule.

Callie also echoed the sentiment regarding the necessity of having structure in her recovery process:

There was something super nice about the consistency of the Tuesday/Thursday meetings. I will say that was so comforting. Something about just knowing those nights I was going to be at this group with these close friends. Even when we weren't that close, it was just, like, I knew I had somewhere to be and, for some reason, at this phase of your recovery, I needed that. (Callie, lines 306–311).

Again, for Callie, having the structure of the Tuesday and Thursday rehearsal process was comforting in her journey toward recovery.

Other participants also spoke to the benefit of structure, but looked at it with less intensity; rather than it being a necessity, they viewed it as an element that was helpful to their recovery process. Sidney noted, “It was a stepping stone, so to speak, especially with the meetings twice a week” (Sidney, lines 518-519). Victoria also expressed the helpful nature of structured time during recovery: “So, I had a lot of free time and I was living by myself . . . so, it was good to have that set time, twice a week, that we meet up” (Victoria, lines 81-83). Whether participants found it a necessity or helpful, it becomes clear that the ability of Recovery Through Performance to provide continued containment through structure for participants was a benefit of the project after treatment regarding the recovery process.

Abstaining from physical eating disorder behaviors. Abstaining from physical eating disorder behaviors specifically addressed the way in which the continued containment of the project supported clients in not engaging in physical eating disorder behaviors that would lead to a relapse. Such behaviors include restricting, purging, bingeing, over-exercising, and laxative or diet pill abuse. Four participants specifically mentioned how the project provided containment through abstaining from physical eating disorder behaviors. Similar to the previous subcategory, some participants viewed the support the project provided around abstaining from physical eating disorder behaviors as a necessity, compared to those who experienced it as supplementary to their recovery process after treatment. Raj, for example, specifically mentioned the containment of the physical aspect of relapse of an eating disorder, stating, “I don’t say this as a cliché, but it may have saved my life in the sense that I didn’t fly off any handles, I didn’t relapse or anything like that” (Raj, lines 123-124). The containment of the project was experienced as a necessity to not having an eating disorder relapse. Megan also shared a similar sentiment regarding how the process aided her in not engaging in physical eating disorder behaviors, such as restricting or over-exercising. Megan said, “I remember leaving rehearsal and thinking this is the first time in weeks I haven’t wanted to skip dinner or haven’t wanted to go for a run” (Meghan, lines 114-117).

Because each rehearsal began with an optional peer-led meal support, some participants described that using that option helped them comply with their meal plans and not engage in restriction of calories. Piper described how she used and needed the consistency of the meal support provided by the project to help her make physical food-based recovery choices:

I think I was the only person who consistently showed up for meal support before rehearsal, which I needed at the time. Like, [I] really make this decision to come in and eat my meal and make this recovery choice. (Piper, lines 293-298).

In all three examples, continued containment was provided through helping participants abstain from physical eating disorder behaviors.

At the other end of the spectrum, participants also mentioned more *supplementary* aspects of the project in aiding them to abstain from physical eating disorder behaviors.

Sidney described her experience of wishing she had used the support sooner:

I started using the meal support that was offered before the rehearsals. . . . I always thought, “I’d do this, oh, next time. I’ll do it. I’ll go next time.” And I never went. So, the second half of the rehearsals, I started going to the meal support and then I thought, “This is cool. I regret not doing it earlier, but I am grateful that I came around and did it” (Sidney, lines 254-256).

This statement exemplifies the supplementary way in which continued containment around meal support was beneficial for Sidney in her recovery process. Whether participants received containment through structure or helping them abstain from physical eating disorder behaviors, both were benefits to participating in Recovery Through Performance. Containment is necessary to help reduce eating disorder behaviors and help clients be accountable with their time. When a client has containment in his or her recovery process, it helps the client shift the focus to being able to begin to focus on other areas of recovery, such as relationships, which is described in the next category.

Category 2: Fosters Relationships

Category 2 emerged as a representation of the ways in which the project fosters relationships. As noted in the literature review, the need for a community and healthy relationships is at the cornerstone of eating disorder recovery (Noordenbos, 2011). Often, clients struggle to have meaningful relationships because of the fear of committing to anything other than their eating disorder and fear of rejection. The first subcategory was

teaches commitment, where the Recovery Through Performance process helped participants address and work on commitment, a backbone to being able to being in a relationship. The second subcategory was building relationships, in which two properties are present: functional and meaningful. Properties are an additional differentiation to the subcategory, providing more depth and detail. Functional relationships describe the way in which clients were able to build relationships that they could utilize in the here-and-now during their recovery process. Meaningful relationships describe the relationships that were described as deeper, long lasting relationships that extended beyond the boundaries of the project. Each of these subcategories is examined further below.

Teaches commitment. In this subcategory, three different participants spoke to the way in which the project taught them commitment. At times, it was begrudgingly and other times willingly. What seemed most important was their commitment was linked to the relationships with others in the cast—a sense of needing to show up for the collective. For example, Callie shared how she typically struggled with making commitments and, in the process of the interview, recognized that it was, perhaps, the nature of the project and how people were counting on her that allowed her to show up, rather than isolate and avoid relationships:

I knew we were allowed to miss one (rehearsal) and I have an issue with absences when I am struggling with my eating disorder. I miss things or show up late. I didn't miss a single rehearsal, which I just thought about, which is really interesting because she said, "You are allotted one to miss" . . . but there was something about it, where I think it's, like, other people are counting on me . . . I just need to be there. . . . So as much as I wanted to isolate, I knew there was a reason I had to get up. There was a reason: I had to show up for these people. I had to show up and it was going to happen. The show was going to go on, rain or shine; we were going to have rehearsal. There was something about that commitment that felt really good. (Callie, lines 313–320 and 678–681)

This statement exemplifies how the project helped participants work on commitment, which in return helped create fertile ground for relationship building.

Megan also spoke to the same issue. She was working at a coffee shop at the time and was regularly scheduled to work weekend shifts. Being a part of the project required that she attend the weekend-intensive, which conflicted with her work schedule. She often spoke about it in rehearsals, citing how it was easier to just be at work than attend to some of the emotional and personal aspects of the project. In the interview, she specifically addressed the moment in which she chose to commit herself to the project, which, in return, resulted in fostering relationships with the group:

I took that weekend off of work in order to have it. So, I was like, I went in, okay, I'm doing this. I'm committed . . . then having those individual intense experiences with the group, instead of just one on one, that's what I think solidified everything. (Megan, lines 249–251)

Although it was just one weekend, Megan's risk to commit to the project allowed her to be available to individual experiences, which helped build a foundation for relationship building.

Ellie also shared a similar sentiment. Although begrudgingly, she noted how she pushed through difficult days to show up, because she had made the commitment to her fellow cast members. She noted,

And some days you just don't want to socialize or be with anyone, or just feel at your lowest and you just want to be in bed and sleep the day away. And you have to push through and get up because you made the commitment (to the cast) and you have to show up. (Ellie, lines 467–469)

In all three of these examples, the project taught commitment, which helped foster relationships for participants. By choosing to fully participate in the project, clients practiced commitment, which fostered relationships via encounter.

Builds relationships. Perhaps the most discussed topic was the subcategory of builds relationships. One property of building relationships was that they were functional, meaning that the project, on a surface level, provided a way to meet new people and be surrounded by people to receive support after intensive treatment for an eating disorder. The dimension of this property was from high to low. An example of the low end of functional, were comments such as “I met new people” (Raj, line 100). On the high end of the spectrum were statements such as “The support through this project from other people was significant” (Ellie, line 235). Furthermore, on a functional level, the project seemed to serve as a functional reminder of the need for relationships in recovery. As Sidney stated, “But people with eating disorders tend to keep to themselves. . . . So being in co-active theater is, again, like putting that right in the forefront and pushing that down and saying, ‘I do need people’” (lines 495–504).

Along those same lines, she also described her process of integrating into the group:

So it was really helpful in becoming more connected to people. Connecting outside of treatment is very different, more than I anticipated. And I kind of went from being an outsider, which is how I feel in groups...and I kind of went that weekend from being an outsider in that group, to actually, like coming in and feeling a part of the group. (Sidney, lines 128–132)

Others spoke to how the relationships in the group helped them feel less alone in the recovery process. Raj, for example, mentioned, “And I was also with a group of peers that [*sic*] were going through the same emotions as I was, so I was not alone” (Raj, lines 280-281). Callie noted that, when she was struggling during the week, she had the relationships to hold onto to help her get through: “Even if it was, like, a Sunday, I’d be, like, ‘Okay, two more days and I am going to have my people. And maybe I can make it through today because I know I have my people’” (Callie, lines 674-675). In these

comments, on the high end of the dimension, the project helped her to build functional relationships, which supported her in pushing through challenging times in her recovery process.

Whether it was a low or high level of functionality, six out of seven people commented on the project supporting them in building relationships, which served them in a functional way regarding recovery. Simply put, people in recovery need relationships for functional support purposes and participants found that need met in Recovery Through Performance.

In the second property of builds relationships, participants described when relationships that were built during the project moved beyond initial functional purposes and became meaningful. In this property, the dimension was from meaningful relationships during the project to beyond the project. In meaningful relationships during the project, there were examples of ways meaningful relationships were cultivated and maintained during the project, such as by getting to know someone more deeply while doing the show. At the other end of the spectrum, beyond the project, participants spoke to the ways meaningful relationships extended after the project was over.

Regarding meaningful relationships during the project, an important aspect was that theater seemed to have helped be a conduit to developing those meaningful relationships during the project, which is discussed further at the end of this chapter. For example, Raj said, “I cultivated relationships that were even stronger because of the rehearsal process of the project itself” (Raj, lines 100-102). Similarly, Callie commented on how the nature of performance allowed her to get to know a fellow cast member in a deeper, more meaningful way:

With therapeutic theater, you got to know the whole person. I had no idea Victoria can sing! She has an amazing voice. It gives me goosebumps. She is so incredible and, when she sings, she transforms. It made me feel closer to her. I had no idea, and I probably could have gone to group therapy for 3 more years and never knew [*sic*] she could sing. . . . You just get to know the whole person, rather than just going to a group therapy session, where it is, like, you are just talking about the issue and then you leave. (Callie, lines 613–618)

Further along on the continuum, some participants spoke to meaningful relationships that extended beyond the scope of the project. Megan noted after 2 months, “I still talk to the people that [*sic*] I did the play with. We still have that community with each other” (Meghan, lines 165-166). Victoria echoed a similar sentiment: “I feel like I could go and text one of them and we could meet up and it would be fine. What’s missing after treatment is, like, it’s bringing the community in” (Victoria, lines 412-413).

In this category, it was clear that the project, and more specifically theatrical elements of the project, helped foster relationships in numerous ways, from providing a base of teaching commitment to creating space for relationships in the here and now to long-lasting relationships that reached beyond the boundaries of the project itself. Once clients began to have relationships, they could begin to consider other areas of their recovery process, such as practicing emotional self-regulation, as discussed in the next category.

Category 3: Practicing Emotional Self-Regulation

Emotional self-regulation is the capacity to “learn how and when to trust our emotional compass” (Aldao, 2014, p. 2). This process is essential for clients with eating disorders because the eating disorder has often been the tool that has been used to deal with and regulate emotions, rather than the client knowing how to do that for himself or herself. For example, when a client is feeling angry and does not know how to regulate that anger, it may be regulated through the process of bingeing and purging. When a client

can not deal with emotions at all, he or she may restrict food to numb out those feelings. In this project specifically, every single participant noted that the project allowed him or her to connect to emotions and expand his or her comfort zone, both elements of learning and practicing emotional self-regulation.

Connecting to emotions. Several comments were made about the process of connecting to emotions and being vulnerable in those emotions in the presence of others. Of particular note, and as discussed further at the end of the chapter, the use of performance and theatrical tools specifically seemed to help facilitate the process of connecting to emotions. The dimensions of this subcategory are from connecting to resisting to embracing. For example, Sidney, on three separate occasions in her interview, described how performance required a connection to emotions and vulnerability and how she was able to move towards embracing connection this more throughout the course of the project:

I feel like doing theater is standing up, is really putting yourself in a vulnerable state, putting yourself in a state to be judged . . . you have to take off some masks in order to be in a performance. It was scary and it was vulnerable. . . . I mean, the play performance, in one sense, was so raw and real. (Sidney, lines 505–512)

Callie also expressed a similar experience, moving towards embracing her emotions, regarding performing as something that is connected to your own personal story: “It was, again, just vulnerable. It’s like putting something out there about your life story, now it’s putting something you have created out there. These are pieces of me” (Callie, lines 503–505).

Raj also described how the play represented feelings from his own life and story and that, through that process of sharing with an audience, he was able to practice embracing his own feelings more: “And even on stage, just being open and honest about

how your feelings are and being okay with owning your feelings” (Raj, lines 333–334).

Each of these examples demonstrate the way in which the project helped participants connect to emotions.

Others shared how playing a character was a vehicle that allowed his or her self to connect to emotions. Megan remembered a time in which she was not connecting and how, through being given permission to work through a role, she was able to get in touch with emotions, which benefited her emotional process and her portrayal of the character. Her journey demonstrates how she initially wanted to reject the emotional experience, only later to embrace it in the moment:

I just wasn’t connecting to my character and there was one day that they sent me off with the script with two other people and they were, like, “Rewrite your monologues until you connect with them.” (Dave and Laura) gave me complete freedom to stay in the safety of this character and that story line, so I had distance, but also to put my own therapy in process there. I played Ms. Waits in the play and, by the time she’s been out and she’s been down on her luck for a long time . . . she gets robbed. When I was on stage, I was able to connect to anger or just, like, my own loneliness, or my own, all of these things. I wouldn’t have felt safe enough to just walk on stage and be, like, “I experienced this myself.” I mean, I grew so much from that because, like I said, that safety and practicing it that way showed me I actually can still safely do it in my own life. I can meet friends and be, like, “I had a really bad day, here’s how I feel about it,” with out having to be, like, “It’s fine.” . . . So just having the ability to be authentic and be vulnerable, like, I benefited so much from the play. (Megan, lines 181–198)

Others, like Piper, spoke to how theatrical exercises, like improvisation games, seemed easy on the surface, but also surprisingly provided a safe way to practice self-regulation of emotions. Although initially hesitant to embrace emotions, in this moment in the interview, they celebrated that connection: “But improv, it was pretty, I mean, at first, it was funny, like, happy-go-lucky stuff, but it ended up being really vulnerable stuff, but I was able to do it. And I think that is good” (Piper, lines 303-310).

Ellie also spoke to the use of improvisation exercises, which helps a person to spontaneously connect to whatever emotions may be arising. In this part of the interview, she specifically noted that she had to open up in the writing exercises, but more challenging were the embodied improvisation games in front of the group, which were particularly important in her process of working through connecting to emotions. Like her fellow participants, she also was somewhat initially rejecting, but also could see the embracing benefit of the work:

I did better when it came to sharing personal material through writing, but when it came to being vulnerable, sharing within the room and doing improv exercises, it was more vulnerable. People could see on my face the reactions. Yet really powerful. (Ellie, lines 357–361)

Megan also spoke to the combination of both role-playing and improvisation and how they helped her with connection to emotions. In particular, this exemplifies how she was highly resistant to the drama therapy work because of how it would connect her to emotions. She eventually was able to embrace the powerful shift within herself. In the following excerpt, she described an improvisation exercise where she was asked to play a unicorn that was pretending to be a horse (a metaphor for a life situation she was experiencing at the time). In a moving moment in her interview, she reflected on this experience and how it supported her in connecting to emotions:

She [Laura] wanted me to improv this character who wants a future but can't have it because of something they think they are [*sic*]. I was, like, okay, we are going to do this emotional thing. And she had me improv it by pretending to be a unicorn who had to pretend to be a horse. And I was so angry in that moment because I was, like, "Why am I connected to this!" . . . That was probably the first time in the play I was vulnerable at all and did it in a silly way, but I think those first few times of being so uncomfortable, it was the most challenging. . . . When you are in group therapy, they are not going to ask you to be a unicorn in the middle of the room. While they are both extremely beneficial, for me, this was a much better way to process and grow emotionally. I was being a unicorn and my life was changing. (Megan, lines 606–619)

Others spoke to the fact that the process as a whole helped foster connection to emotions and benefitted from sharing that with others. Victoria identified not only the challenge of opening up, but also moving towards embracing her goal of connecting to emotions.

When asked impromptu by the interviewer if she met the goal, Victoria shared, “I felt, like, by the end, I’d met it 90%” (Victoria, line 342).

Expanding one’s comfort zone. Part of emotional self-regulation includes the process of expanding one’s comfort zone. When one’s comfort zone is expanded, there is more flexibility and access to a wider range of emotional experiences and capacity to regulate one’s self. Because very few of the participants had ever even been in a play, the act of just participating was, in and of itself, a way to expand their comfort zone. More specifically, five of the seven participants had never participated in a theatrical experience. Many participants spoke to the fact that part of what is difficult about trying new things is the feelings that could be brought up in the process, especially failure. By expanding each participant’s comfort zones in their own ways, small to large, participants could work through emotions that might have been brought up in the here and now. Sidney shared how “just the act of getting out of your chair and doing things that feel uncomfortable” (Sidney, line) benefitted her. Callie also shared that “It forced me to do things outside of my comfort zone” (Callie, lines 158-160) and that was useful for her in regard to seeing that she could handle taking a risk and managing her emotions.

As the process progressed, others found themselves taking more ownership to expand their comfort zones. For example, Megan said, “I would check in at the beginning of the group about how my day was going or about how I was feeling and try to put myself out there more than I was comfortable with” (Megan, lines 230-232). Whether

through the theater process or the group process, it was clear that members were able to work on their emotional self-regulation through learning to connect to emotions and by expanding their comfort zone. When those who struggle with an eating disorder are able to have more access to emotions and the capacity to regulate emotions, there becomes more space to deepen the process of recovery, as is explored in Category 4: advancing psychological recovery.

Category 4: Advancing Psychological Recovery

In the final category, participants spoke to the ways in which the project allowed them to continue working towards advancing psychological recovery that they had started in higher levels of care and move it into exploring and mastering those areas on a deeper level. Six subcategories presented themselves: unfinished business, cognitive distortions, taking up space, authenticity, relationship to the body, and being an agent of change. Each subcategory is described in depth in the following subsections.

Unfinished business. Unfinished business is a term coined by Perls (1969) that speaks to psychic material that has not been fully processed and is causing distress or impairment in a person's life. Perls recommended a person needs time and space to address unfinished business (Landy, 1996). When a person has the opportunity to do so, he or she internally and externally becomes more whole. In this category, five participants spoke to how the process allowed them to continue to address and deepen work around their own personal unfinished business. The dimension of responses ranged from expected to unexpected regarding working on unfinished business during the project, meaning that some participants were aware of unfinished business and were able to continue to purposefully address it in the process of the project. Others unexpectedly

stumbled upon issues about which they were not yet aware and were given the space to begin to examine and work through those issues.

One example of expected unfinished business was when Raj described how, in treatment, he had an opportunity to begin working on unfinished business and how this project created an opportunity for him to continue that work. He furthered this sentiment by indicating that, if not for the project, this work may have been left unfinished. He stated, “I had to share a lot of my personal stories in this play. I had to talk about the stuff I may not have to had to talk about anymore after treatment” (Raj, lines 255-257). Ellie also explained how she had unfinished business around grief that she needed to address in her personal work and described how the project was another venue to continue to do so: “And so, it was really good for me in bringing up so much loss and the feelings that loss bring up and the grief” (Ellie, lines 313-314).

Callie, who had lost her mother to cancer when Callie was a young teenager, was surprised at how much of her unfinished business was brought up through working on the play. Although she was aware of the unfinished business, there were still some unexpected elements to working through it during the course of the project:

But by the second rehearsal, when we were just doing improv games, somehow I was still crying because it was hitting nerves and things I haven't, like, dealt with for a long time . . . like, my mom passed away from cancer, so in the script, my character has a mom who left her. So, then she wants forgiveness, and I have a lot of unfinished business. I wish I could have said to my mom what I said in the play, but she got sick. So Laura used that to help me get some closure. (Callie, lines 548–552)

Sidney also expressed in the interview how, unexpectedly, an exercise brought up grief around the loss of her horse, which had been a coping tool for her when she was in the thick of traumatic experiences in her life and important for her to have space to process:

But then, once I was speaking to my horse who had died and I don't even know how I got to that, but it was really hard because I had to put my horse down, like a month before, of 20 years. So I remember that group and how it was. (Sidney, lines 184–187)

Megan also commented on how the process, in a more general way, gave her the space to process many feelings and how she unexpectedly found some catharsis and release:

Because, all of a sudden, I would start connecting to my character and the exercises and just allowing things to come up for me, but I would leave rehearsal feeling like almost released in a way. Like, I had gained a sense of peace and re-centering. (Megan, lines 105–108)

This category revealed the potential that Recovery Through Performance has to advance recovery through allowing participants to continue to address both unfinished business about which they were aware, as well as bring light areas that still needed to be discovered as part of the healing process.

Cognitive distortions. Beck (1979), a behavioral therapist, coined the term cognitive distortions. His theory on cognitive distortions is widely practiced by both behavioral and non-behavioral psychotherapists. Cognitive distortions are irrational beliefs that perpetuate a person's self-concept and often impair someone from being able to be present in the world. Four participants discussed different ways in which the process of the project forced them to address cognitive distortions. The dimensions of the subcategory of cognitive distortions ranged from unresolved to resolved.

Many of the participants specifically spoke about the process of getting feedback from other participants, facilitators, and audience members in regard to challenging their cognitive distortions. These interactions often forced participants to reality-check their internal negative self-talk. One example was when a bucket of water spilled on stage on opening night of the play. In the following scene, the goddesses fell from the sky and one of the participants, Callie, ended up soaking her costume on stage. Internally, she had

been anxious and worried people were judging, yielding her rumination on the wet dress for the duration of the performance. She shared this moment in the interview and how feedback from the audience forced her to recognize that her cognitive distortion was not true and, at least momentarily, she was able to resolve the distortion.

My dress was wet from the water and I felt like a mess and people were still hugging me. I tell myself the only way people will like me is if I am always okay and on and everything and looking okay. So when I was really not feeling that way and people still came up to me and were, like, “That was so great!” and treated me the same way, it kind of made me address that theory. (Callie, lines 432-438).

Piper also shared a similar moment in which she, in her head, had been creating cognitive distortions about her self-worth and, at the end of the play, found an audience member directly reflecting a different, more positive, self-image to her, which helped her come closer to resolving her own distortion:

She came up to me after and gave me a big hug and told me I had a gift, which feels good and I was, like, at the same time, “Who are you? You don’t know anything!” It’s my own dismissive stuff . . . and I got this in my feedback from other people, like, my friends came and saw it . . . and [said] that they were proud of me. (Piper, lines 391–395).

Victoria also spoke about how she struggled to take in compliments because it challenged the internal narrative in her head, which contributed to fueling her eating disorder. For her, when friends and family gave her compliments, it was easy for her to dismiss them, but in this process, having an audience that was unfamiliar with her, aided in her capacity to hear the feedback differently. She shared how the process was both difficult for her—and still unresolved—but important: “It’s really hard for me to take any compliments and to take them for their word. So, I got a lot of compliments, not just from my friends, but from random people who thought I did a good job” (Victoria, lines 281-285).

Many of the participants talked about how taking feedback was difficult for them. Often, for clients with eating disorders, their perfectionism takes hold and they internalize critiques or feedback as personal criticism, which plays into their cognitive distortions about their self-worth. In this process, Raj, Callie, and Victoria each talked about how this project helped them hear feedback as supportive rather than personalizing it to their cognitive distortion schema. In the next passage, Callie, described receiving feedback from facilitators and learning how to hear it differently, helping her to resolve some of her cognitive distortions:

Like, rehearsals are the one place where criticism is not really criticism. It's love. Because I have a really hard time with criticism, so I would deliver a . . . , like, and they would be, like, "Okay, this time, less goofy, more this." And inside, I was, like, "Oh god, you were so goofy, that so embarrassing." It might sound silly, but in my head, I started going down this spiral of being, like, "that's so embarrassing." So, I had to learn how to take it in and not see them as saying there is something wrong with me. . . . I really have to deal with the way I take feedback. This is a play. They are not saying something is wrong with you. They are saying, "Try delivering the line this way," not "How dare you!" (Callie, lines 242–249)

Later in the interview, Callie elaborated on this experience and discussed the process of how putting personal material in the play was also a way to challenge cognitive distortions:

But hearing someone else read something I wrote, have to perform it and everything, it was cool, but also that part of me thinks, "I'm not good enough and I am not okay." Seeing someone else take your words seriously and deliver them really beautifully kind of puts that voice away because they think that those words are beautiful. (Callie, lines 489–495)

Victoria also spoke about how difficult it was to take feedback and how the process of receiving feedback helped to desensitize her: "I don't like to hear the critiques, but I also think that's good, because in life, you are going to hear critiques, obviously. So, again, it is kind of just desensitizing in a way" (Victoria, lines 207-209). Raj similarly

stated, “Being okay with myself to perform and getting positive feedback or challenging feedback and taking it as a way to improve instead of [being] insulting” (Raj, lines 516-518).

This subcategory demonstrates the ways in which the project benefited participants by helping them advance their psychological recovery through challenging cognitive distortions. In the next section, the way in which the project helped advance psychological recovery through being able to take up space is presented.

Taking up space. For clients with eating disorders, the issue of needs and space are large. This category represents the ways in which the Recovery Through Performance process facilitated clients becoming more comfortable with taking up space. *Taking up space* is defined as feeling worthwhile to be seen and heard. Participant interview responses ranged from *apprehension to embracing* of taking up space. Four clients spoke to this experience in the project. Victoria described how clients with eating disorders struggled with taking up space and how performing helped challenge that area:

I think people with an eating disorder, a lot of us struggle so much with taking up space or being seen, so, to have to be on stage in front of people and to have to own it . . . I speak generally for everybody, but for me, that’s all true. (Victoria, lines 702–705)

Similarly, Megan described how doing a monologue alone on stage challenged this area in her life and resulted in her embracing taking up space:

I’ve always struggled with being seen. I want to be in the background more often. So, Dave and Laura had me on stage [by] myself, doing a monologue. I benefited by exposing myself in that way and learning to be okay with it. (Megan, lines 200–201)

Sidney also described this experience, specifically noting how creating a play from personal material helped facilitate the process of taking up space. Although with

apprehension, she stated, “And it happened so fast in my mind, that I’m not wanting to take up space. But it takes that to work with personal material” (Sidney, lines 192-194).

Callie was also apprehensive and expressed how being a lead role and having many lines facilitated her practicing taking up space: “It’s hard for me to take up that much space because I had a lot of lines and people had to sit and wait for me to be done with my lines and watch me” (Callie, lines 180-181).

The project and its theatrical aspects seemed well suited for benefiting clients to physically, emotionally, and verbally practice taking up space and feel worthy of doing so.

Authenticity. One reason clients often fear giving up their eating disorder is because they do not know authentically who they are underneath or outside of the disorder. Clients fear, if the mask of the eating disorder is pulled back, there will be nothing underneath. The eating disorder has become all-consuming, often leaving clients not knowing who they are or what they like. Therefore, the process of developing authenticity is essential in the recovery process. *Authenticity*, in regard to this project, can be defined as a sense of exploring who one is in the world and making decisions that feel congruent with one’s own wishes and desires, rather than from a place of pleasing or meeting others’ needs. Six of the participants spoke about the process as being one of discovering or uncovering their authentic self, or experiencing a level of internal and external congruence.

In the dimension of this subcategory, participants described both the process of authenticity as emerging or they were actively cultivating authenticity through the process. Raj, for example, mentioned, “It was a lot of self-discovery. I didn’t expect all of

the soul-searching” (Raj, line, 137). Megan also spoke to feeling more congruent when she stated, “I fell more into, like, a self who I really am, like, in an authentic way, without being overwhelmed” (Megan, lines 271-272). Victoria shared how she had loved music for so long and felt a sense of being at home when she sang; however, her eating disorder took the priority and focus in her life for a long time and she became so consumed with her eating disorder that there was no longer space or time for music. When she had the opportunity to sing in the play, she felt reconnected with an authentic part of who she was and inspired to continue to cultivate that within herself: “Also, because of this (project), because I sang in the play, I discovered that I really had missed music . . . and I have been thinking about more ways to incorporate music back into my life” (Victoria, lines 122-124).

Sidney shared how the performance helped facilitate her speaking her truth about her eating disorder diagnosis and accepting it as a part of her narrative. In the following excerpt, she shared how she initially obstructed authentic parts of her story, but through the project, began to cultivate acceptance of her authentic narrative:

It felt real. In some ways, I was accepted as I was, like, accepted for who I was and what I was doing and what I am working through and what my process has been. I mean, there was hesitation to even invite people to the play, just because I haven't told a lot of people that I am in recovery or that I came to Saint Louis for treatment. I am kind of coming into a space where I am telling more people.
(Sidney, lines 368–374)

The process also helped Callie become more internally and externally congruent. During much of her life, she hid her truth due to feeling pressure to please others and present herself as being “okay.” In her interview, she expressed how the process of performance let her recognize the difference between authenticity and inauthenticity:

I spoke to the fact that I have struggled with having, like, a façade on and, like, a lot of my life, done a lot of performing. By that I mean smiling all the time, even

when I am hurting inside. No one knows what's going on with me because I'm really good at it, so I've always thought it's kind of like everyone's my audience and I'm kind of on stage in my life. So when I was really on stage and there was a real audience, it was kind of cool to, like, tease out my life. Like, I don't need to be performing. Performance is when you are on a stage. Like, I'm in a play, I'm performing. I don't know. When I was finished with the play, I was, like, "These people in your life aren't, like, audience members. They're, like, people on your life." I've been treating a lot of people in my life like they are my audience and I have to, like, perform and, like, be on. And so when I actually perform for an audience, it was kind of a cool thing where, like, "Oh, this is really an audience." (Callie, lines 391–403)

Through performance, Callie was provided the opportunity to work through what a real audience is versus a fictional one.

This section explored the ways in which the Recovery Through Performance project, and specifically the performance aspect, helped advance psychological recovery through creating an experience and environment that helped participants shed their eating disorder identity and find new ways of exploring themselves authentically.

Relationship to the body. In this subcategory, participants spoke to the ways in which Recovery Through Performance used body-based techniques that helped support them in advancing psychological recovery in regard to their relationship to the body. Helping clients foster a positive relationship to their body is imperative because an eating disorder works to completely disconnect a person from his or her body, and the body is often the recipient of abuse from the repercussions of an eating disorder. Participants described the relationship with their body within the dimension of functional to instrumental. *Functional* was defined in this category as recognizing that the body is a tool some individuals use for helping to shift their relationship to their body. Acknowledging the body is a tool implies the body has some value, as opposed to the perspective that the body is useless and deserves to be mistreated. Others were able to move past simple acknowledgement of the essential purpose of the body into the

recognition that a body can be essential in regard to connecting the person to his or her mind and spirit.

All participants also noted that theater inherently challenges a person to confront his or her relationship to the body, which is discussed further at the end of this chapter. Three participants specifically spoke to the evolution of their own relationship to their body through the project. Callie perhaps best summarized the experience in her interview:

I think the fact that you use your body in theater in everything you do. Even in a role where you're standing up straight, you're still using your body as a tool and your body is a gift in the theater, in a way, because a lot of times, I feel, like, "This thing in the script doesn't make sense," and Laura will be, like, "It will make sense with acting it. Your body will explain it." I'm like, "Okay." And it's true! So, yeah, your body, I don't know if I've ever felt, like, "Man, my body! I'm so appreciative of it today!" But it's, like, you do need it when you're acting and I think when you spend so much time loathing it and then in a position where it's your tool, you must foster some sort of appreciation for it. . . . There was this one part where I'm rolling on the ground and Piper is on top of me and, like, we fell from the heavens. I think about it. I am able to roll on the ground. I don't know if I've ever felt this at this time. I'm so glad you can do this. I don't know. Its, like, while you're acting, you really need it [the body], so I think there are a lot of times during the day where I stop now and I'm, like, "I need you right now," and during acting, I can't imagine how you would portray something without gesticulating, like, doing something to explain it. So, I think that's the best way people with eating disorders, it helps them realize that their body is more than a shell. (Callie, lines 631–651)

Megan also recognized the way in which her eating disorder disconnected her from her body awareness and relationship to her body and reflected on the process of rediscovery. Here, the essential way in which she realized the body helped her sync up the mind-body experience: "I'm putting it in my body and allowing my body to remember what that feels like, when my eating disorder so long has shut my mind off to what it feels like" (Megan, lines 667-669).

Sidney expressed the ways in which the process forced her to directly confront her negative body image, though she was perhaps still seeing the body as functional, she had worked to challenge her negative relationship to the body:

Being on stage and the performance part of it brought body image up, and body image is a hard one to step out of when that's been, like, such a focus . . . (performance) brings that right to the forefront. There's no getting around it. So, by doing it this way, you just have to push through it and it doesn't get its day. (Sidney, lines 490–492)

The theatrical nature of Recovery Through Performance, at a minimum, challenges clients to be in their bodies and, as described above, can even provide a means to build the relationship with the body.

Agent of change. *Agent of change* is defined as the recognition that those who have been wounded have great potential to use their journey and recovery to give back to others as a part of the healing process. Every participant addressed the role of giving back to the community as an important part of their participation in the project. The dimension for this category is from weak to strong. On the weak end, participants spoke to it as feeling cool or feeling good about being able to give back to others. On the strong end of the spectrum, participants recognized and embraced their new role in the community as being a person who has the capacity to be an agent of change in his or her own life and in the lives of others. Perhaps in the earlier stages of recognizing her capacity to be an agent of change, Sidney shared, “We were able to touch people” (Sidney, line 334). Others, such as Megan, described an experience in which a person she did not know asked to get together with her to discuss relevant topics of the play. Here, Megan began to discover her strong capacity to be an agent of change:

And I've talked to so many people since the play that [*sic*] are, like, really identifying with this. I had people Facebook messaging me and being, like, “I

don't know you, but can we meet for coffee? Because I really want to talk to you about how this play affected me." (Megan, lines 397-404).

Megan was able to go out with this person and began to develop into a mentorship type role, based on this interaction.

Callie also shared how unfamiliar audience members who were touched approached her and recognized the strength of her capacity to be an agent of change:

Everyone I spoke to, and there were a lot of people that [*sic*] came up to me that I actually didn't know, which was really crazy, but people were just saying how they feel everyone in recovery needs to see this and people who aren't in recovery, too! I think everyone is recovering from something. (Callie, lines 415-418).

Raj described the experience as bestowing a gift to the community, an experience that he also recognized was a gift for himself: "And it's a blessing to be able to perform in my opinion. It is amazing to give the world something that was created by our different stories" (Raj, lines 400-403).

Megan also reflected the reciprocity of the process of herself as an agent of change for others, which, in return, supported her ability to keep changing herself:

Yeah, so, I think it engaged a lot of people and I think that was, like, a gift to me as well to see that it bring more community that authenticity. I feel like I've been given so much in my process and during the process of the play, like, invested so much, for all of us to feel, like, I was giving back was wonderful. (Megan, lines 409-413).

Though different unique experiences, each participant was able describe some sort of experience as an agent of change and the benefit of being able to give back to the community.

Another important aspect was also found in emotionally touching the audience and making space for their own vulnerability, a process that mirrored the participants' work. Part of the co-active therapeutic theater model is that the cast members design an

activity that they facilitate in being co-active with the audience. In this production, the cast decided to ask the audience what was most difficult for them about being vulnerable. Callie discussed this moment as a strong example of being in the role of someone who has the capacity to be an agent of change:

And I think, from reading people's journal entries at the end, was so cool. I figured people poured their hearts out on those pages. And I think that proves people need this stuff. People need to be asked and have the room to answer, and I think this gave people an opportunity. (Callie, lines 457-454)

Piper also discussed how the project touched the audience and the impact that it had in her own journey: "And they really enjoyed the play and found it funny and powerful and heartbreaking and exciting . . . and it had, it kind of embodied on stage, for people, to see was pretty powerful" (Piper, lines 398-399).

These emerging categories began to answer the research question: through the process of therapeutic theater, participants benefited by engaging in a process that provided containment in the recovery process through offering structure and encouraging abstaining from eating disorder behaviors. The process also helped participant's foster relationships through building commitment and fostering functional relationships that helped support their recovery and meaningful relationships that lasted beyond the scope of the project. Participants were able to practice emotional regulation through connecting to their emotions and expanding their comfort zones. Participants also had the opportunity to advance their recovery through addressing unfinished business, examining cognitive distortions, practicing taking up space, working on and discovering authenticity, building a new relationship with their body, and becoming an agent of change to the community.

The Role of Theater as Facilitation of the Change Process

The second part of the research question was intended to examine the ways in which therapeutic theater is different than talk therapy. There are many ways to facilitate change; many clients have recovered from an eating disorder before the inception of this project. The salient point is there is a well-documented lacuna in the treatment continuum, and Recovery Through Performance was designed as a response to that. Because theater processes are at the core of the project and the co-active therapeutic theater model, it was essential to outline the unique properties of theater. In this section, I discuss areas that clients identified as ways in which they experienced theater as beneficial and different than talk therapy, as well as offer my observations. Clients were required to be in their own personal therapy during the course of the project, and a few participants noted how the process aided them in their personal therapy, as well as how personal therapy aided them in the group therapy process.

Distance and the Use of Role

One of the primary ways that theater is unique is its use of role-taking and distance. As noted in the literature review, role-playing allows a client to play a character who has qualities that can represent where they have been, who they are now, or who they hope to be. Each client, in his or her interview, noted ways in which he or she played a character from whom he or she learned. Raj, who had participated in the pilot project of Recovery Through Performance, played a very different role than his first time. In the first production, Raj played the lead role and the hero of the show. He often described the confidence he took away from the experience, which was evident in his interactions, acting, and mentorship to other cast members in this production. In *Twin Falls*, Raj was

purposefully cast in a smaller role. His character, Troy, had begun to achieve his dream of owning a pet shelter, which also had morphed into a type of shelter for people. Raj had written very specifically in one journal entry about his dream of owning an animal rescue facility one day, so this was specifically written into the play, as an opportunity for Raj to embody a role on the stage that he hoped to one day manifest in his own life off of the stage. In the interview, Raj reflected on playing the role of Troy and the pride of being cast as a character who was a good man:

And it was very heartwarming to be that character. And I was just thankful that they thought of me that way too. . . . Troy ended up going through a lot of pain, but then ended up being this kind-hearted, compassionate, just heart-warming man that [*sic*] followed his heart. I'm playing this character and I am hoping that I can be like that. That I can also follow my heart. (Raj, lines 228-229)

Callie also discussed her transformative process through role-playing. In the beginning of the rehearsal process, Callie often discussed how she was struggling to be the “leading lady” of her own life, she often experienced people seeing her as the “best friend” and the girl who never “gets the guy.” This created an important opportunity for her to actually play a lead role. She reflected in the interview the experience of having to play a lead role and how that helped her address active ways she wanted to be the leading lady of her own life:

My character was one of, like, I guess, if you were going to say it, one of the lead roles. And I've always struggled with being, like, the leading lady of my own life. I was, like, “Oh no, I'm, like, a lead role and I barley feel like I allow myself to be a lead of my life.” . . . My character was feminine and she was beautiful and was this really strong character, someone that I would love to be like, but I disowned that stuff about myself. That was something really great. (Callie, lines 163-164).

It is clear from this comment the way in which having to take ownership over being a lead role and playing a feminine, beautiful, strong character helped facilitate more embodiment of these qualities within herself in her life off of the stage.

Sidney particularly had an interesting experience regarding the use of role in relationship to helping her expand her role profile. Sidney, at the time, was struggling to hold on to recovery. She was quite rigid and struggled the most in the beginning with improvisation and flexibility. In the show, we cast her as the guide figure, and more specifically as a goofy, imperfect, quirky guide. Initially, she was overwhelmed by the role, feeling as though she could barely find recovery, so the stretch to play not only someone who was recovered, but also was a guide to others seemed impossible to her. However, by the end, she exuded confidence and reflected in the interview what she learned from playing a role that seemed so far outside of her repertoire:

It was really beneficial to come back and step into my character and have the experience of. So, it's almost like I have the experience of being on the other side of, like, having worked through my process and made it to the other side. . . . I really liked being able to create a story for Belle, my character, and when I was in Belle, be, like, in her story and kind of have this energy of, like, badass-ness that I was really attracted to. I like going from working on my personal stuff and then working on a character. (Sidney, lines 162-165)

Megan also had a tough time with the casting, at first. In fact, the way in which the script was originally written, Megan felt it was unrealistic; in this case, we had stretched the character too far outside of the realm of possibility for the participant. However, because the co-active therapeutic theater model dictates that the drama therapist-director and cast members work together on each aspect, this provided Megan the freedom to rewrite her scenes until they were within her reach. Initially, Megan wrote that her character did not get to stay with the new community at the end of the play, but throughout the process, as she pushed herself to stay with the cast and become more vulnerable with her fellow castmates, she had the courage to allow her character to begin to do so on stage. This action was reflected externally in her internal transition. She reflected,

There is even a point, my character, at end of the play, my character comes back in and meets this community. She has been looking for community her whole life. No, that's not how it works in real life! You don't just get robbed and then you get a happy ending. . . . I had to push myself to stay in the community, to allow my character to stay there and have somewhat of a happy ending. . . . And how that is my exact process . . . because I've done this play and learned this. I'm still scared, but I'm going to allow my character to stay in the last scene in the community. (Megan, lines 305-310)

Co-active therapeutic theater is particularly unique in this way, not only from talk therapy, but also even from other creative arts disciplines: an art piece may not be able to be changed so drastically at the end for an art show, or certainly not a music piece, or even in a set script, such as *West Side Story*; the characters stick to what has been written. But in this interview portion, we saw the way in which Megan was able to grow and advance through playing the role and how co-active therapeutic theater specifically made space for such dramatic shifts and captured them in space and time.

Ellie also experienced growth through the role she played. We had predicted, in the beginning, that she would be distraught by having to play a good-enough mother who took care of herself and could go through a process of rupture and repair—the very opposite of her own mother. She reflected on the journey through her role in the interview:

At first, I was really upset because my role was so different and difficult for me to play. And so, Leda, my character, was everything that I've wanted but believed I didn't deserve. But there's something incredible about the model and bringing therapeutic art drama play into it, because you are playing all these roles and it makes you step outside of yourself, but then, as you play this role, you realize that this role becomes you, or that, really, you have had this role in you all along. (Ellie, lines 298-302).

As discussed in the first part of this chapter, role-playing and distance were used to help facilitate change in the participants. Role-playing supported participants' work on emotional regulation. Through connecting to their own emotions, participants were able

to bring a role to life, or through playing a role, they were able to get in touch with emotions that were previously not acceptable. The distance offered in role-playing and improvisation allowed participants to safely experience emotions and address unfinished business. Taking on a role allowed participants to expand their comfort zone and to challenge cognitive distortions.

Healing and Connection is Expedited

Another way that theater is different than talk therapy is the depth and speed in which the process works. Action methods, in general, have been studied for their capacity to work with the right side of the brain in a way that taps into material more quickly (Weiner, 1999). Participants also spoke to this when directly asked about the difference between therapeutic theater and regular group therapy. One group member spoke to how she was in group therapy for a number of months before there was cohesion, whereas participation in the therapeutic theater process brought the group together in a faster way. She explained,

So, I joined an outpatient group and the outpatient group probably took 3 months before the group started to feel cohesive and like a safe place to bring personal stuff to. But this gives you more cohesiveness from the get-go. (Sidney, lines 467-474)

Other group members shared similar experiences in comparing talk group therapy and co-active therapeutic theater. One participant simply stated, “It connects you deeper” (Ellie, line 628) and another said, “It fast-tracks trust, being able to trust the group a lot faster” (Sidney, lines 478-479). Not only do these comments corroborate the literature review, but also are an important consideration when looking at the time-sensitive period after intensive treatment for clients with eating disorder. During the early stages of recovery, time is of the essence. Clients early in their recovery can easily fall into relapse;

having access to a process that deepens the work and creates a community of trust and cohesiveness more quickly certainly becomes a fundamental building ground for the other benefits that the project offered.

Additionally, it seemed the multidimensionality of the work in therapeutic theater helped create more avenues for processing, which seemed to expedite the work. As Ellie shared, “It’s not like this one-dimensional group therapy work that’s done. It’s a two-dimensional and three-dimensional process, working on all kinds of things” (Ellie, lines 609-612). Megan also shared in this experience: “It creates so many more avenues for me for processing. I think it has so many more opportunities” (Megan, lines 674-675). This is discussed throughout the categories as well in participants’ discussions of therapeutic theater as a process that makes space to continue to work on unresolved issues or as a way to fast-track building relationships after treatment.

Ultimately, clients seemed to agree that theater is particularly useful as compared to talk therapy due to offering different ways of processing and the unique capacity of theater to fast-track the continuation of the treatment and recovery.

Performance

The culmination of a performance was perhaps one of the most obvious ways that therapeutic theater and talk therapy differed. Performance also distinguishes this type of drama therapy from other types of closed-drama therapy groups. As noted earlier in the chapter, and in the review of literature, one aspect that is important to later stages of recovery is being able to become an agent of change, first in one’s own life, and then in the lives of others. When asked about the differences between group talk therapy and therapeutic theater, one of the most important areas that participants noted was being able

to give back to the community, which, in this case, was facilitated by the performance and the participants creating an element that was co-active with the audience. Participants spoke to this aspect not only as benefiting from becoming an agent of change in the community, but also in specifically regarding the uniqueness of the collective spirit of creating a theatrical performance. Five of the participants spoke to this in the interview when asked how theater was different than talk therapy. They specifically mentioned the act of creating something together and the focus on the collective. Ellie shared,

This is different in the way that everyone brings something in. We're all bringing something in right from the get-go, and we all continue to bring it in, so it's not just one person's work, it's everyone's work. There is something really big about taking therapeutic work and having the whole group be a part of the process. (Ellie, lines 598-602).

Ellie spoke to how the therapeutic theater process required people to open up for the sake of creating a script. In group talk therapy, clients have the option to share or not to share. In this process, even if it was in a distanced way, clients had to bring material to the table and, in enacting one another's material, the focus (unlike group therapy) stayed on the collective.

Sidney and Piper identified a similar experience. Piper shared, "But it's rarely about one person in the moment, it's like the group at large, the whole cast at large" (Piper, lines 482-484). Sidney also stated, "I guess there is more of a collective spirit to the group, there's this project that everyone is working on and thinking about and kind of coming from their own individual places to a unified center point" (Sidney, lines 464-467). This collective spirit to create a play helped to solidify the next step, which was the performance, in distinguishing how talk therapy and therapeutic theater are different. Victoria stated this clearly when she said, "And also, it's different because you are sharing something with people. With this, you're inviting people and telling them

whatever you decide to tell them” (Victoria, lines 357-358). Performance also arguably helps provide containment and structure. A show requires regular rehearsal, which naturally provided a set structure for participants. Furthermore, the performance helped build relationships because in a play, the entirety of the cast must be present to put on a show; therefore, group participants felt a sense of commitment to their fellow cast members to show up so they could help forward the collective. Performance requires a level of emotional stability and connection to move through the process and also aids in expanding one’s vulnerability and expanding one’s comfort zone, as examined in the categories.

Use of Body

Another tangible difference between talk therapy and therapeutic theater was the use of the body. As Callie simply stated when asked the difference between talk therapy and theater, “I think the fact that you use your body in theater is significantly different” (Callie, lines 631-632). Not only is this useful for clients with eating disorders, as expressed earlier in the chapter, but also creates a way in which clients cannot “hide out” from the work. Many clients spoke to how they could, in talk therapy, hide under blankets or stay not connected to their body, whereas theater forced them to connect to their body, and connection to the body helped facilitate connection to emotions, authentic self, and other benefits participants mentioned.

As Megan shared, “Anytime I put anything in my body, like throwing a broom because my character is angry, I’m going to feel angrier more than if I was just sitting and talking about anger” (Megan, lines 663-665). As also mentioned earlier, for clients with eating disorders, learning to appreciate the body and build a relationship with the

body is a core process in recovery from an eating disorder. In theater, the body is the only tool one technically needs; therefore, the theater required the participants to examine their relationship with their body. The show could go on without props or costumes, but not without the body functioning. In this process, participants began to recognize the body as a precious tool, rather than something that had previously been a source of shame or hate.

Parallel Process

Yalom (1985) discussed the concept of the group therapy process as being a microcosm of the macrocosm. This theory is often applied to most group therapy processes; however, something that seems to be unique to therapeutic theater is that the process of rehearsal has many parallels to the process of recovery being beyond just a microcosm of the macrocosm. Yes, patterns of behavior in a group therapy space are representative of the outside world, but in co-active therapeutic theater, even more elements are present that mirror unique aspects of eating disorder recovery. Ellie perhaps best captured this in her statement in comparing being ready for the performance to being “ready” for recovery:

I think that the final ending, you’re so, beforehand, heightened with anxiety and wanting to get in an extra rehearsal, because you don’t feel prepared enough, it’s kind of like life in recovery, right? When is it going to be the best time? You could have given 4 more weeks and probably we would have still said, “We’re not ready!” Because when is going to be the best time? When is it going to be the best time to be in recovery and start living your life and going through the recovery process? (Ellie, lines 485-491)

Victoria talked about it in a more concrete way. In improvisation, risk taking and learning that type of flexibility is a necessary skill of survival in the theater, as it is in recovery:

If you think about it in terms of . . . you’re kind of just rehearsing life when you come out of treatment. So, you don’t really know how it’s going to go, it’s kind of

like (improvising) in a way, just like try things out and see what happens.
(Victoria, lines 230-233)

Similarly, Piper talked about how, in recovery, there are real aspects of having a concept of what recovery is like, but not having experience with actually having lived it. Similarly, in co-active therapeutic theater, the process of writing, creating, and putting on a play felt just as elusive:

I guess, in the beginning (of rehearsals), like, coming into something that you really, like, have an idea about, but you don't really, like, have a working concept of what's going to happen. And I think that's similar to recovery. Everyone talks about, like, "You need to be in recovery." Then you get in it and you are, like, "I don't know what I am doing!" But somehow, you stick with it; it, like, makes , , , it's so cliché, but stick with recovery and you'll make a life. (Piper, lines 325-331)

Sidney shared somewhat of a different experience of the parallel, in which the process of recovery felt counterintuitive to her, from her eating disorder running the show for so many years. Similarly, she explained how, often in theater, doing the opposite of what might feel natural paralleled the same process in recovery:

I guess, in some ways, it's, like, practicing, like they say in our recovery, "Do the thing that feels wrong." Like, it feels wrong to order the sandwich or it feels wrong to have a snack when you are in a hurry. Like, doing the wrong thing and doing it anyway is what is going to take me into recovery. In rehearsals, early on, it felt really awkward and wrong. . . . You do what feels wrong because you're trusting the process and you're trusting that it's going to mesh, that it's going to come together (Sidney, lines 275-281 and 305-307)

Although talk therapy and therapeutic theater both offer ways of applying the microcosm to the macrocosm, it appeared from participant interviews that co-active therapeutic theater and its processes specifically paralleled experiences unique to recovery, perhaps more than talk therapy alone.

Touchstone Experience

Another unique differentiation that the participants noted was the project served as a touchstone experience, both in the here and now of their lives as well as extending beyond the work. Participants were able to take away tangible moments, lessons, and experiences and apply them to their recovery process and world outside of rehearsal space. Given the fact that the process was so dynamic, it is possible that this creates more unique experiences to remember teachable moments, rather than talk therapy. Many participants shared more simply how the project gave them something to hold onto during difficult times in their recovery process, such as Raj, who said, “Recovery Through Performance helped a lot. And that is something that I can hold onto” (Raj, lines 125-126). Later in the interview, Raj expressed shared how he held onto what was learned: “It was so necessary for bringing back into my home afterwards. And that strength would help me carry on through my recovery” (Piper, lines 194-197).

Sidney discussed how, when old patterns of eating disorder behavior emerged, the ways in which the project gave her a new way of experiencing the world gave her courage to apply it to her life in the aftermath of the project:

So, I find myself wanting to go back to old patterns of presenting what I believe people want to see so that people can connect to what they want to connect to and forsake myself in doing that, but (now) not doing that, instead holding onto the space and the creation that is being open to people and I guess just doing it differently. (Sidney, lines 338-346)

Megan spoke to how theater created a peak experience for her, which translated in a moment she could call upon when struggling to connect to her emotions in her personal individual therapy. She specifically noted the play as the peak experience in fostering the touchstone experience:

That specific moment was, like, life-changing for my process. Because now, every time I go into a therapy session, I can be, like, “I’m going to feel this and I’m going to be fine when I leave and feel better about it.” It was so good, like, can we do the play every day? I never imagined I would have grown so much from doing the play. I never imagined that 6 weeks later, I would be thinking about my character and what the next right thing for her would be or thinking about the play and everything it taught me. It’s, like, part of my story in my recovery, in my life, in my perception. (Megan, lines 120-124).

Although perhaps group talk therapy could be a touchstone experience, it seemed that embodied theatrical processes lend themselves to more possibilities of creating lasting, memorable experiences that participants could call upon far after the close of the work.

Summary

This chapter provided the participants’ perspective of results a 7-week co-active therapeutic theater project. Participants’ responses were developed into four categories that answered the original research question regarding the benefits received from participating in a therapeutic theater project after receiving intensive treatment for an eating disorder. The benefits they received from the project in regard to their eating disorder recovery were as follows: First, the project provided containment in regard to both giving structure to participants’ daily schedule after treatment as well as helping them abstain from using physical eating disorder behaviors. Second, the project fostered relationships by teaching commitment, which helped lay the groundwork for clients being able to both meet people and develop meaningful long-lasting relationships. Third, the project helped clients become aware of emotions and practice emotional regulation. Fourth, the project helped advance psychological recovery through helping clients look at their unfinished business, addressing and challenging cognitive distortion, allowing them to practice taking up space and feeling worthy of doing so, working on viewing their own

selves as capable persons in the word, helping build a healthy relationship to their bodies, working on discovering and cultivating authenticity, and providing an opportunity for clients to be in a role of being an agent of change to those in the community.

Furthermore, this chapter offered analyses of participants' responses to answer the second research question regarding how therapeutic theater was different than talk therapy. Participants identified a number of different ways that theater was different than talk therapy, which also corroborated with the review of literature, and that they experienced as helping to facilitate the benefits they received from the project. These included: (a) the use of distance and role-playing, (b) that the healing process feels expedited due to the multidimensionality of the project, (c) the use of performance, (d) the use of the body, (e) that the rehearsal and performance process paralleled the process of recovery, and (f) that theater created touchstone experiences that participants could hold onto beyond the conclusion of the project.

In the next chapter, there is further discussion of the results in relationship to the literature, limitations, and future directions.

CHAPTER 5:

DISCUSSION

This chapter presents a discussion on the research of this study. First I will share additional participant feedback relevant to the process. Second, I will examine the results and model through a social constructivist lens to help the reader consider how this theoretical orientation is relevant to transferability. Third, I will present other considerations of unforeseen issues that may arise. Finally, I will crystalize the research with existing literature on recovery and eating disorders and consider why this work answers the call to therapists for interventions for this population.

Participant Feedback

One aspect that needs to be addressed is participants' feedback that did not fit into the categories or the discussion on the difference between talk psychotherapy and therapeutic theater. This next section discusses additional themes from participants and my personal reflection regarding the process of the project and considerations for future replications of the project.

The most important area that was mentioned was facilitation of the project. Thus, it may be important to highlight my experience, when examining this. My experience not only includes a Master of Art degree in drama therapy, but also doctoral-level coursework in counseling and supervision. Additionally, I bring 9 years of clinical experience to the table and 6 years specifically in working with eating disorders and the use of drama therapy with clients with eating disorders, in multiple levels of care, which allow me to understanding the progression of eating disorder recovery. I have published in the area and spent extensive time thinking about how to facilitate dramatic

embodiment with clients who hate being in their body. Furthermore, my colleague, Dave Mowers, who co-created the co-active therapeutic theater model, also brings significant experience. Dave was first a professional director in Hollywood for a number of years and later got his degree in drama therapy from the same institution I attended. He works as a member of the faculty of New York University, teaching a course in therapeutic theater.

Our combined experience, I believe, truly allowed us to navigate challenges with a sensitive population that I do not believe anyone without theater, therapy, and eating disorder training could do. This was evidenced in the 23 different times that participants brought up facilitation in the interview, unprompted. This seems important in that participants were being interviewed by an outside person and were not coerced. Also interesting was that sometimes participants directly commented on how it was my or Dave's facilitation that helped them achieve the benefits stated previously. For example, in the literature (Costin, 2012), it was noted that building relationships is essential to recovery, and that benefit was found in the project. In the interview, Callie noted that her witnessing my co-facilitation with Dave helped serve as a model for her relationship-building process:

Oh, something else that was interesting was seeing the way that Laura and Dave interacted, like partners, on this project. I think it was really healthy because they were not always, like, "Do you like this idea?" "Yeah for sure, go for it!" It's not at all like that. There were times when Dave was, like, "I don't like that," and Laura was, like, "I do," and he was, like, "I don't. I don't think it works." And she was, like, "I don't know, I think we should try it." And they're, like, okay. I was like, "Oh, they are not fighting, they are like dear friends and this is okay." Because I avoid confrontation or I rarely speak; like, I don't want to rock the boat, so, like, in friendships, if someone's, like, "I don't like that," sometimes I go "Yeah, that's fine," even though, no, I do like that. So, seeing how they interacted and they were still totally respectful. We're, like, disagreeing about things and

that helped me see that's a normal way of having a friendship. That was just something extra, too. (Callie, lines 270-282)

Another important theme that emerged was participants who spoke about the delicate balance in facilitating between letting the clients have enough autonomy and self-responsibility so they could take ownership over the project and being there to empower and support clients when they needed more help. Megan referred to a moment when Dave and I knew we needed to give her more autonomy so she would not rebel against the difficult things she was being asked to do in the script that were outside of her comfort zone. Ultimately, we knew she needed to make the decisions for her character's fate on her own (a metaphor for her own life, as well):

I think the great thing about Dave and Laura was they, like, came in with the script and then I wasn't connecting to my character and then they sent me off with two other people and they were, like, "Rewrite your monologue until you connect with your character," . . . complete freedom . . . and Laura kept being, like, "It's up to you, whatever you want to do." Thinking about it now, that was huge to changing my process, and empowering. (Megan, lines 179-187)

Callie also described this process of the balance between therapist, director, and empowering the participants to find autonomy to parallel their recovery process:

Yeah, I think at the beginning, like, Laura really held our hands through it and not, like, in a babying way. We showed up and we started right away, but she was really, like, leading. She was saying, "We are going to do this, now we are going to do this." And yeah, even though she was the leader all the way through and that she helped break things down and everything, by the end, we were really kind of rocking it on our own. She would be working with people on one thing and we would go work with people on another thing. It's like; she kept giving us more and more space and taking more ownership of the project. (Callie, lines 343-355)

She continued and later expressed, "I think she was that perfect in-between, still commanding. She's still the leader, but also she was one of us and never treated us like we were less than" (Callie, line 702-704).

Ellie also shared a similar viewpoint: “By having someone come in and guide you, direct you, witness you, push you, encourage you, that throws in a really cool effect in relation to everything [you are working on in recovery]” (Ellie, lines 416-418).

Raj, as well, articulated the balance of qualities: “I call them, you know, leaders, Dave and Laura, they were very supportive, they were very kind and compassionate. They challenged us appropriately, there was no shame whatsoever” (Raj, lines 277-279).

Participants also articulated that it couldn’t just be a theater person. For example, Megan described the complex balance of the role of facilitation:

It wasn’t, like, a director, you’re on stage with your lines, “Read a little louder, a little softer.” It was, like, “When have you felt this way before?” And “How does this connect to your character?” “Say the line 10 different times and see what feels right for you because this is your character, your story,” and just pushing us to really really connect or feel whatever we felt that character would feel. (Megan, lines 361-266)

Callie also articulated the delicate balance in her statement: “I think she was that perfect in-between, still commanding. She’s still the leader, but also she was one of us and never treated us like we were less than” (Callie, lines 702-704).

In their unsolicited feedback regarding facilitation, the clients also noted that the assistant to the project (a student on the drama therapy alternative route) was less skilled in facilitation, which caused anger and frustration. As Raj mentioned,

One thing I wish was different was her assistant. This person didn’t quite understand the eating disorder. And I understand that this person was currently in school and everything, but it was clear there was a lot of misfiring, a lot of concepts that weren’t perceived or even that she stopped to think about before saying something that would be, at times, detrimental to the process. (Raj, lines 479-482)

Callie echoed this in stating,

And I think we spoke with Laura about it [being] really important that the person leading it, they [*sic*] need to be a special kind of person, and that might be asking a lot. You can’t throw any counselor in there, even if you have a social work

background or whatever it is, you can't just throw someone in there. . . . Like I said, at the beginning of this experience, the person is sort of like a mother hen and everyone is following. And then, by the end, it's, like, "Okay you can do this and go out on your own." (Callie, lines 686-690)

Finally, there was a similar theme around the level of presence and energy needed from the facilitator. Participants expressed this in a number of different ways. Piper bluntly stated: "Laura is a badass teacher and she knows it" (Piper, line 635). Victoria said, "I felt like it was really helpful just having Laura there, just because she could kind of call it out—I don't know—she would be able to make it more fun" (Victoria, lines 90-91). Raj similarly described the energy that Dave and I brought as being important, in two separate occasions:

I knew Laura's talent and just her raw energy and raw outlook on just everything and her presence is just so worldly. Because she just creates this space for healing . . . and just seeing them (Dave and Laura) go up and do their bit. I just couldn't wait to see how they interacted; it's always a hoot. They are great together, the talent and raw energy that just emanates from them. It's unbelievable and it carries the people around. And they created something for us based on what we created with them, so it was just really cool to see what came together on stage based on our stuff with their help. (Raj, lines 168-170)

Although perhaps a bit uncomfortable to write about, this unsolicited feedback from participants is crucial when thinking about the replication of the intervention or similar projects. Persons wanting to create a similar project should consider being experienced in eating disorders, or partnering with someone who is, should have solid training in theater and drama therapy, as well as polished micro- and macro-level individual and group counseling skills. Furthermore, another possibility is that Dave and I could write a training program for the co-active therapeutic theater model, and those with counseling or other mental health credentials could get trained in the specific model. It would seem that having a base foundation of being a mental health professional is the priority, followed by getting additionally training in the use of theater.

Participants also had a number of suggestions, both personal to themselves and ideas for future runs of the project. One of the biggest realizations for a few participants was regarding whom to invite to the performance. There was wariness for a few of the participants regarding inviting some essential people in their lives whom they were having a rocky relationship with or feared would not “get it.” Both Victoria and Sidney stated they, ultimately, wished they had invited those people. Victoria said, “I would have wanted my father there, so I would have been more proactive in asking him and telling him I wanted him there, because I didn’t” (Victoria, line 320). Sidney also stated, “Definitely, it would have been to invite more people to come to the performance” (Sidney, line 420). This is important for future projects to address with participants because it is another way of encouraging vulnerability, expression of emotions, and challenging perfectionism. Having experienced this now, as a facilitator, I would have preemptively had these conversations with the cast and parsed out if participants were struggling. In the future with this, I would share these sentiments.

The other major piece of feedback was that the project happened in too short of a period of time. During the pilot run of the study, it took place over the course of 16 weeks, which felt too long. This time, we moved it to 8 weeks, which participants were clear was too rushed. Callie said,

We’ve talked a little bit about this as a group, but I think it felt a little rushed at times. I know Laura is planning on trying to make it a little longer. I think two weekend intensives would have been really helpful. (Callie, lines 520-523)

Raj agreed and also pointed out that having two weekend intensives would also strengthen the process. He said, “It was very fast, almost too quick. I wished it had lasted longer . . . to do two weekend intensives per project. That would be, absolutely, hands down amazing” (Raj, lines 291-292).

Moving forward, 10 weeks would be my next suggestion about the amount of time to engage in the process. Without a doubt, adding a second weekend intensive is a good idea, and we also realized that the co-facilitator should fly back in for the performance. Even though Dave was only with them for one weekend, his ability to come in and challenge the group dynamic, offer an outsider perspective, and allow clients to clients to form another attachment is invaluable.

Finally, an unexpected piece of feedback from participants was around the journals. Participants noted that after the script was written, their use of journals decreased and they wished they had continued. It would seem that, as noted in the social constructivist psychotherapy literature, that journaling offers the ability to continue to reflect and develop on ones constructed narrative, which could further support participants in the process (Neimeyer, 1999). Additionally, they wished that they had a peer to trade the journal entries with, which is something that Dave and I will be writing into the model as a way of allowing the narrative process to be further developed.

Additional Limitations and Considerations

Additionally, there are some other limitations and considerations that relate to participant feedback and the project in general that should be considered. One hope is that this project is transferable to other communities and eventually other populations in recovery. Taking this into consideration, it would be important to consider what might be some issues that could arise that did not occur in this project, but could unfold due to the acuity of the population being worked with. As noted in chapter 2, there are some criteria that are built into the model that ideally support such issues as relapse or suicidality. These include requirements such as having a weight criterion, which acts as a

metaphorical “carrot” for those motivated to be in the project. Another is that participants must be in their own individual therapy, which ensures safety and another place to process feelings that are being stirred up being a participant. However what if someone did become suicidal? Or have a full-blown relapse? Or quit the project? Or people found themselves feeling more isolated, rather than building a community? Questions such as these are important to have on the radar for anyone attempting to engage in such work, and can be considered in two ways: facilitation and constructivism. For example, I imagine that if a person had to be hospitalized for becoming suicidal during the project, that the facilitation of this experience is essential. The facilitator, by understanding both dramatic intervention and constructivism could offer interventions to meet many difficult situations. So, let us say that a client does become suicidal. The facilitator understands that drama and metaphor would be used to work such experiences into the script or dramatic play in a metaphorical way that would allow the group to process and construct a narrative around that experience in whatever way would be meaningful for them. If a participant had a full-blown relapse that experience could actually be an important experience, as relapse is often part of the recovery process and perhaps that cast would work to co-construct a way to symbolically represent that within the work. Or if relationships are a struggle (which they will always be when the stakes are so high!) that the facilitator knows the right types of exercises that dramatically warm the group up to be able to playfully address or examine such dynamics. My recommendation is that for anyone embarking on such complex and meaningful work is the understanding that any occurrence becomes a gift for the group to work through and co-construct meaning.

When the facilitator's narrative becomes the primary objective, rather than being in collaboration with the participants, the project is more likely to fall apart.

Furthermore, on a practical level, facilitators should know the nearest psychiatric hospital; they should have the contact information for each participant's therapist and be sure to be the last one to leave the space, ensuring that no one is left behind on the grounds.

Another limitation is that while this research was conducted in the spirit of constructivist qualitative research with its creativity and experimental nature (Merriam, 2009), it is still highly exploratory in nature. At worst, this could mean that the findings are so specialized and specific that they may not be significant or applicable when considering transferability. Additionally, although I worked to address researcher bias, my reputation and connection specifically with the Saint Louis eating disorder community may have a larger influence than even noted in the previous section on facilitation and despite efforts made to address biases and keep objectivity, to some degree it is ever-present in qualitative research.

As Atieno (2009) noted qualitative researchers must also accept that "ambiguities which are inherent in human language" (p. 17) are always present when analyzing text. Furthermore, she noted that qualitative researchers are working with small numbers, which must be taken into consideration when considering the bigger picture in the context of research. Moreover, qualitative research is time consuming and expensive making on-going research challenging, which I certainly could see being an issue regarding transferability of this study in particular. Additionally, the unique individual attention that each participant needs could be challenging to meet. Atieno (2009) also

noted that the small numbers of participants of qualitative researchers and the continued bias of policy makers regarding the efficacy of qualitative research remains an issue.

A final limitation consideration is that this study is specifically interested in filling a gap in the continuum of treatment, which would require that the higher levels of care have adequately addressed (to some degree) core issues for clients with an eating disorder. However, all higher-levels of care are not created equally. Therefore, this intervention may not be applicable or appropriate depending on a participant's previous treatment.

On the positive side, at best, this study could offer a groundbreaking application of therapeutic theater to fill an important gap in the eating disorder treatment continuum, that is not reliant on managed healthcare standards and meet the unique needs of each individual.

Social Constructivism Considerations

As mentioned in the previous section, the lens of social constructivism and skill of the facilitator are, in part, essential considerations in future iterations of the project. However, a social constructivist lens also offers a way of understanding the data and the model, at large, particularly in considering transferability of the model.

At the crux of the co-active therapeutic theater model is collaboration and co-authoring, which is a shared experience between the participants, facilitators, and the audience. This co-authoring, I would argue, is the driving agent of change to the process of recovery. Obviously, the lived-experience of an eating disorder is a major part of a person's life. Some treatment approaches would have the client working to move past such unpleasant experiences, or worse, covertly expressing that if the client recovers they

could just think of the eating disorder as “something of the past,” a bad memory to be “forgotten.” Instead, I am arguing that to truly recover from an eating disorder, and moreover, maintain recovery from an eating disorder, the process is dependent upon the client’s ability to have a meaningful shared experience in a healthy, facilitative context (as in therapeutic theater).

Unlike a therapeutic theater piece that uses a pre-set script or the creation of one script, the co-active therapeutic theater model allows for the script to be a living document that can be changed at any moment—including during the performance, if need be. As noted in the results, many clients benefited from this freedom of narrative construction in the form of a play. I believe theater takes the narrative construction to the next level, allowing the participant to more deeply embody the narrative, blurring the lines between their lived experience and the constructed performed narrative. It is, perhaps, within this liminal space that change and possibility become limitless. Script writing and performance are social activities, and the writer-performers are enmeshed in the process. They share the experience and process of constructing a message and of engaging in its performance. This melding of experience with socially constructed meaning is classically representative of the social constructivism philosophy—finding a truth in shared experience (Cottone, 2012). In this sense, the social constructivism lens may be aptly applied as a descriptor of the experience of the participants.

The co-active therapeutic theater model also works particularly well with clients with eating disorders, as often the disorder has hijacked a person’s life. The model lends itself to engaging in a social constructivist type of therapy that is particularly useful for those who are just recognizing that they can, with others who share similar experiences

that are enlivened in the theatrical context, construct meaning in their lives. Collaborative action in social constructivism makes space for discussion about whether the participants are headed in a desired direction. If asked if they are achieving their goals, the answers can then be put into tangible narrative action in the play space of theater. The opportunity to make and to share experience, rather than just report it, becomes highlighted and lived in the body on stage.

Finally, even the choice to use a qualitative framework is congruent with the process of the work and the actual need of clients, rather than what managed health care would specify. Qualitative research values multiple narratives and voices, holding that there is no single knowable truth. Additionally, postmodern research “is highly experimental, playful, and creative, and no two postmodern studies look alike” (Merriam, 2009 p. 10). The very structure and system of managed health care is part of the reason why adequate treatment and recovery options do not exist.

Insurance companies operate out of an empirical, knowable, single truth, and deem one only receives treatment if they are below X pounds. However, as noted in the literature review in chapter 2, this information is in direct opposition to what is actually necessary as a part of recovery. Recovery is a multi-faceted, dimensional, narrative process comprising of significantly more than being at a certain weight point. Hence, this study prioritize the social constructivist nature of the work and conducting research in a way that is congruent with that model, which in return is congruent with what those persons in recovery actually need, versus conducting a study that fits into what insurance companies are looking for. Currently, many treatment centers or those creating interventions work to mold to the desires of insurance companies to ensure that their

company gets paid, rather than the focus being on honoring the unique narratives of the complexities of an eating disorder and its recovery process.

All of this is to say, that those interested in transferring the project to their community must focus and priorities engaging in a post-modern lens in both the execution of the project and in subsequent research. In the next section, I will continue to drive this point home by specifically referring to the aforementioned literature.

Findings Related to the Literature

One of the most promising findings from this study in relation to the literature was Noordenbos's (2011) taxonomy on comprehensive areas that a person in recovery needs to address and work through. Noordenbos mentioned eating and drinking, physical activity and exercise, attitude towards food, body evaluation, physical recovery, psychological recovery, emotional regulation, relaxation, social relationships, sexuality, and comorbidity. As indicated in the categories, many of these areas were identified by participants as benefits of being a part of the project. The project supported eating and drinking, as evidenced by Category 1: containment. The project built in optional peer meal support and required participants to maintain a certain level of recovery through providing structure and abstaining from physical eating disorder behaviors. Physical activity and exercise are inherently built into the process of theater through acting and games of improvisation, choreography, and other theater exercises.

To be in a performance requires physical stamina and care for the body, as mentioned in the section on the difference between talk therapy and therapeutic theater. Attitude towards food was not directly worked on, nor mentioned by participants in the categories, but through metaphor and the process of examining eating disorder recovery

as the topic of the play, it was certainly included in the process. Participants in Category 4 noted body evaluation, particularly advancing recovery and the subcategory of relationship to the body. Participants directly discussed how the process of being in a play and using the body as a tool helped increase a more positive relationship to their body. Psychological recovery was not only worked on, but also was identified as a category in the project. As Noordenboos (2011) said, psychological recovery occurs when the person

has developed a “sense of self”; has self-esteem and a positive evaluation of herself; has enough self-respect; has a positive attitude of herself; self-esteem is not dependent on weight or food intake; has a positive feeling of identity; is assertive enough to express her own opinions; is no longer overly dependent on the opinion of others; has a feeling of autonomy; is able to concentrate; has no maladaptive cognitions about food, weight, herself, her body, or others; is not overly perfectionistic; has no extreme fears of failure; has a realistic self-image. (Noordenboos, 2011, p. 444)

Many of the subcategories in Category 4 directly address these areas. Self-esteem is similar to the subcategory self as capable, “sense of self” is similar to self as capable, being assertive enough to express opinion is similar to the subcategory of taking up space. Noordenboos (2011) also mentioned emotion regulation, which was also its own category in this research, in which participants in the project were able to connect to emotions and express emotions in a healthy way. Social relationships were also clearly addressed in the project in Category 2: fosters relationships, in which participants in Recovery Through Performance were, as Noordenboos (2011) wrote, able to participate “in social activities, is able to establish social contacts and to make friends, feels comfortable in contact with others; is no longer socially isolated” (p. 444).

Other noteworthy similarities between the literature and the finding from this research were recommendations of themes that needed to be addressed in the course of

recovery. As Federici and Kaplan (2008) noted, clients in recovery need to have motivation to recover as well as the understanding that recovery is a process. They need to learn to develop relationships and they need to learn to tolerate negative emotions, all of which were named by participants of this research as benefits to participating in the Recovery Through Performance project. Peterson et al. (2012) suggested that persons in recovery need to construct an identity and find normalcy, find alternative ways of coping with emotions in their day-to-day lives, work through the grief and loss, and understand the negative consequences of an eating disorder. Again, each of these areas were addressed or worked on directly in the process of using therapeutic theater.

Finally, regarding the eating disorder literature, this research answered an important call from Woodside et al. (1998) and Olmsted et al. (1994) regarding the need for specialized treatment for clients the first 6 months to a year after hospitalization. Additionally, because drama therapy and creativity in counseling continue to be emerging fields, any research that supports the efficacy of these modalities is an important contribution.

Another important finding had to do with the experience as “expediting” the therapeutic work. As participants often noted, they felt as though the work went deeper, more quickly, and more could be accomplished. It is unclear whether this was due perhaps to the way embodied psychotherapies work on the brain (see Siegel & Bryson, 2012; Wiener, 1999; Wood & Schneider, 2014) or that intensive immersive experiences provide an environment where the process can be expedited or more deeply experienced, such as a multicultural class involving studies abroad, a service learning project through a college, or even virtual reality immersive experiences that expand metacognition (Dede,

2009). Either way, the reasoning behind the experience of work being expedited or deeper certainly requires further research efforts.

Also, the interview process seemed to provide an opportunity for participants to further reflect and make discoveries regarding their work. Through the semi-structured interviews and post-performance meetings, it seemed that participants were afforded the opportunity to construct a summative narrative regarding the process and to co-construct with one another a consentualized “truth” regarding their experiences (Cottone, 2012), which afforded further meaning-making and solidifying what they could take away from the project.

In conclusion, the findings of this study answer a call put forth by previous researchers to develop innovative treatment options for clients after hospitalization for an eating disorder. The findings from this study directly relate to themes that numerous researchers have outlined as being necessary to address as a part of the recovery process from an eating disorder. Finally, the study revealed that drama therapy and its efficacy remain vastly under researched. This research revealed a fresh use of therapeutic theater and, to this writer’s knowledge, is the only study that has been conducted that examined the use of therapeutic theater in regard to recovery for an eating disorder. Additionally, this study refused to mold to the requirements of managed health care, but rather attended to unique narratives of individual lived experiences to co-construct a new, fresh, and creative intervention to address a problem.

Future Directions

The first natural future direction of the project is to rework the model based on participant feedback and run the study again, adding to these data and perhaps expanding

the methodology to grounded theory. This is already in the works to take place in spring 2017 in New York City. Afterwards, based on future data collection, comparing the model with other creative arts therapy-type groups or just talk psychotherapy would be of benefit. Using the model with other populations such as clients with drug addictions or sexual abuse survivors could help test the model for other populations in recovery. Furthermore, training others in the model and having them use it without Dave or me involved would be ideal to expand on the research as well as to put the model to the test as one that can be transferable. Finally, further consideration regarding using the model and research as a means to address the larger systemic issue of managed healthcare could be considered.

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Appendix A: Category Structure

| Category | Subcategory | Property | Dimension |
|----------------------------------|---|------------|----------------------------|
| Provides Containment | Structure | | Necessity to Helpful |
| | Abstain From Physical Eating Disorder Behaviors | | Necessity to Supplementary |
| Fosters Relationships | Teaches Commitment | | Begrudgingly to Willingly |
| | Builds Relationships | Functional | Low to High |
| | | Meaningful | During to Beyond |
| Emotional Self-Regulation | Connecting to Emotions | | Rejecting to Embracing |
| | Expanding One's Comfort Zone | | Small to Large |
| Advancing Psychological Recovery | Unfinished Business | | Expected to Unexpected |
| | Cognitive Distortions | | Unresolved to Resolved |
| | Taking up Space | | Apprehension to Embracing |
| | Authenticity | | Obstructing to Cultivating |
| | Relationship to the Body | | Functional to Instrumental |
| | Agent of Change | | Weak to Strong |

Appendix B: Code Book

| Category | Subcategory | Property | Dimension | Example |
|----------------------|-------------|----------|----------------------|---|
| Provides Containment | Structure | | Necessity to Helpful | <p>R: "I think this is a game changer for a lot of folks coming out of intensive treatment into the real world, they have some, like, something to look forward to do" (lines 548-551).</p> <p>C: "There was something super nice though about having the consistency of the Tuesday/Thursday meeting... even when we weren't that close yet, it was like I had somewhere to be, and for some reason, in this phase of your recovery, you need that" (lines 306-311).</p> <p>C: "I needed those Tuesdays and Thursdays. Just knowing they were going to happen no matter what was something super comforting. I don't know what it is, but, its like there aren't a lot of things in this world that sometimes you feel like you can rely on to be there for sure, and this was something" (lines 677-670).</p> <p>C: "And I think at that point in your process having something like that, even just twice a week, is so necessary" (lines 673-674).</p> <p>S: "The group came along and that was really really transitional and important. I was kind of slowly regressing into a place I didn't want to be and recovery through</p> |

| | | | | |
|----------------------|---|--|----------------------------|--|
| | | | | <p>performance was twice a week for three hours both times. That's a solid chunk of time" (lines 118-121).</p> <p>S: "It was a stepping stone, so to speak, especially with the meetings twice a week" (lines 518-519).</p> <p>P: "I don't know what would have happened without this play. But to have something to contain me before starting school, to help contain me" (lines, 194-195).</p> <p>R: "And I think the lack of support outside of treatment into the real world is a very real problem and very tough issue to deal with as an adult, or trying to be an adult. And this project, this play, it directly, I guess, plugs into a solution for that" (lines, 590-594).</p> <p>V: "So I had a lot of free time and was living by myself, so it was good to have that set time, twice a week that we meet up" (lines 81-83).</p> |
| Provides Containment | Abstain From Physical Eating Disorder Behaviors | | Necessity to Supplementary | <p>R: "I don't say this as a cliché but it may have saved my life in the sense that I didn't fly off any handles, I didn't relapse or anything like that"(lines 123-124).</p> <p>S: "For me it was like huge in my process to re-engage in recovery and to actively do recovery" (lines 122-124)</p> |

| | | | | |
|-----------------------|--------------------|--|---------------------------|---|
| | | | | <p>K: “I started using the meal support that was offered before the rehearsals after the weekend intensive” (lines 254-256).</p> <p>K: “So the second half of rehearsals I started going to the meal support and then I thought, this is cool...” (lines 258-259).</p> <p>M: “I remember leaving rehearsal and thinking this is the first time in weeks I haven’t wanted to skip dinner or haven’t wanted to go for a run or fill my free time with something that feeds my eating disorder” (lines 114-117).</p> <p>P: “ Well, I think I was the only person who consistently showed up for the meal support before rehearsal which I needed at the time. Like really make this decision to come in and eat my meal (before rehearsal) and make this recovery choice” (lines 293-298).</p> |
| Fosters Relationships | Teaches Commitment | | Begrudgingly to Willingly | <p>C “I knew we were allowed to miss one (rehearsal) and I have an issue with absences When I am struggling with my eating disorder I miss things or show up late to don’t show up on time and I didn’t miss a single rehearsal which I just thought about, which is really interesting because she said you’re allotted one to miss. I think I would certainly on a day when I didn’t feel like</p> |

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| | | | | <p>getting out of bed, like when I'm having a hard day, I would have been like "this will be my day: But something made me show up every single time, which is really cool" (lines 313-320).</p> <p>C: "And yes, that's school and this is different but there was something about it where I think its like other people are counting on me...I need to be there" (lines 330-333).</p> <p>C: "So as much as I wanted to isolate, I knew there was a reason I had to get up. There was a reason; I had to show up for these people. I had to show up and it was going to happen. The show was going to go on rain or shine; We were going to have rehearsal. There was something about that commitment that felt really good" (lines 677-682).</p> <p>M: "I took that weekend off of work in order to have it So it was like I went in, okay, I'm doing this. I'm committed" (lines 249-250).</p> <p>E: "And some days you just don't want to socialize or be with anyone, or just feel at your lowest and you just want to be in bed and sleep the day away. And you have to push through to get up because you made a commitment and you have to show up" (lines 467-470).</p> |
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| Fosters Relationships | Builds Relationships | Functional | Low to High | <p>R: "I met new people" (line 100).</p> <p>R: "And I think the lack of support outside of treatment into the real world is a very real problem and very tough issue to deal with as an adult, or trying to be an adult. And this project, this play, it directly, I guess, plugs into a solution for that" (lines 590-594).</p> <p>R: "Also it's being able to create and cultivate relationships with people you have never met before" (lines 366-367).</p> <p>S: "But people with eating disorders tend to keep things to themselves. So being in co-active theater is again, like putting that right in the forefront and pushing down that boundary and saying I do need people" (lines 495-504).</p> <p>S: "So it was helpful in becoming more connected to people. Connecting outside of treatment is very different, more than I anticipated. And I kind of went from being an outsider, which is how I feel in groups...and I kind of when that weekend from being an outsider in that group, to actually like coming in and feel like I was part of a group" (lines 213-216).</p> <p>C: "Even if it was like a Sunday, I'd be like, okay, two</p> |
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| | | | | <p>more days and I'm going to have my people. And its like, maybe I can get through today because I know that I have people" (lines 674-675).</p> <p>S: So I find myself wanting to go back to old patterns of presenting what I believe people want to see, so that people can connect to what they want to connect to. But not doing that, instead holding onto the space and the creation, that is being open t people and I guess doing it different, like allowing a new pathway, a new direction, a new functionality of relationship" (lines 338-334).</p> <p>V: "But I think treatment is such like a community-driven process, that leaving that community is really hard and really like shell shock. You just don't know, like 'where is my community? They are not here anymore" and then you just have to enter the world. So this is just kind of brining the community (lines 401-407).</p> <p>R: "And I was also with a group of peers that were going through the same emotions as I was, so I was not alone." (lines 280-281).</p> <p>R: "You know, everyone has a story, everyone has fear and this process shows you, you know, you're not alone in these fears outside of treatment"</p> |
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| | | | | <p>(lines 564-565).</p> <p>C: “It was with a group of people that get it, that actually can show up and can understand you without having to spell anything out.” P. 3</p> <p>M: “There were different segments from peoples writings and it was so helpful for them, also helpful for me to even read. I’d be like I relate to that a lot actually.” P. 6</p> <p>E: “You were able to—I don’t—be able to be in that transition and know that someone is going through that transition together” (lines 688-689).</p> |
| Fosters Relationships | Builds Relationships | Meaningful | During to Beyond | <p>M: “I still talk to people that I did the play with. “We still have that community with each other” (lines 165-166).</p> <p>V: “I feel like I could, go and text one of them, and we could meet up and it would be fine. What’s missing after treatment is...like it brings the community in” (lines 412-413).</p> <p>R “I cultivated relationships that were even stronger because of the rehearsals of just the project itself” (lines 100-101).</p> <p>R: “And creating even more meaningful relationships with people you have already met” (lines 367-368).</p> <p>C: “With therapeutic theater</p> |

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| | | | | <p>you got to know the whole person. I had no idea, Victoria, my friend who I was in therapy with for five months, she can sing! She has an amazing voice. It gives me goose bumps. She so incredible and when she sings she transforms not this person. It made me feel closer to her. I had no idea and I would have gone to group therapy for three more years and never knew she could sing.” (lines 613-618).</p> <p>C: “You just get to know the whole person rather than going to a group therapy session where it just like where you’re just talking about the issue and then you leave” (lines 622-624).</p> <p>V: “I feel you get closer, faster, at least I felt like I got closer to people faster” (lines 352-353).</p> |
| Emotional Self-Regulation | Connecting to Emotions | | Rejecting to Embracing | <p>R: “There was a lot of times I came in on the verge of tears because of what was going on outside. And I was able to express that in the beginning and end of rehearsals, and be able to kind of use that energy to put it into the play” (lines 165-167).</p> <p>R: “And even on stage, just being open and honest about how your feelings are and being okay with owning your feelings” (lines 515-516).</p> <p>C: “Might as well be like River and Cody Falls because it felt...I know it wasn’t exactly my story or anything like that but it was so close to home that</p> |

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| | | | <p>I was like there is no escaping the vulnerability” (lines 292-294).</p> <p>C: “It was again just vulnerable. It’s like putting something about your life story, now it’s putting it into something that you have created. These are pieces of me” (lines 503-505).</p> <p>C: “Yeah, there’s so much of acting where I was feeling things I felt and people have to...also there’s this element of people touching you too” (lines 656-657).</p> <p>S: “I mean the play performance in one sense was like so raw and real” (lines 333-334).</p> <p>S: “To take off some masks in order to be in a performance, it was scary and it was vulnerable” (lines 378-380).</p> <p>K: “I feel like doing theater is standing up, is really putting yourself in a vulnerable state, putting yourself in a state to be judged” (lines 505-507).</p> <p>M: “I did it because I need to challenge myself to connect (to emotions) which is funny, because its an acting thing and I was connecting” (lines 94-95).</p> <p>M: “When I was on stage I was able to connect to anger or just like my own loneliness or my own...all of these things” (188-</p> |
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| | | | | <p>189).</p> <p>M: “So just having the ability to be authentic and be vulnerable, like I benefited so much, so much from the play” (lines 197-198).</p> <p>M: “I think I got more used to it, being seen in that vulnerability” (lines 442-443).</p> <p>P: “But improv, it was pretty...I mean at first it was funny, like happy go luck stuff. But it ended up being really vulnerable stuff...but I was able to do it. And I think that’s good” (lines 303-310).</p> <p>V: “So opening up was the biggest challenge for me.” Interviewer: Do you feel like you moved beyond that challenge or..?” V: “I felt like, by the end, I’d met it 90%” (lines 334-342).</p> <p>Ma: “I think it has helped at least for me to, like, open up” (lines 431-432).</p> <p>E: “But when it came to being vulnerable, sharing within the room and doing improve exercises, it was more vulnerable. People could see on my face, the reactions. Yet really powerful” (357-360).</p> <p>E: “And it was just like where I was at, in the space where I was at, and feeling the most vulnerable I’ve ever felt in my life, throughout the whole process” (lines 379-381).</p> |
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| Emotional Self-Regulation | Expanding One's Comfort Zone | | Small to Large | <p>R: "I had never done theater ever...It fit in so well with the theme of trying new things in my life" (lines 102-105).</p> <p>R: "It was just something to do that I have never experienced before" (lines 107-108).</p> <p>I: "What were the ways you benefited?"</p> <p>C: "It forced me to do things outside of my comfort zone" (lines 158-160).</p> <p>S: "I really don't want to like step into this scene as a character, be involved. I wish I could just kind of sink into the chair, but you do it anyway. And you push your comfort zone to explore new space."</p> <p>S: "And then just the act of getting out of your chair and doing things that feel uncomfortable" (lines 476-477).</p> <p>M: I would check in at the beginning of the group about how my day was going or about how I was feeling and try to put myself out there more than I was comfortable with" (lines 230-232).</p> <p>V: "You had to be a part of it, you couldn't sit back, because that was one of my issues when I started IOP, so I meld into the corner. So you really cant do that with this" (lines 355-357).</p> |
| Advancing Psychological | Unfinished Business | | Expected to | R: "I had to share a lot of my personal stories in this play. I |

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| Recovery | | | <p data-bbox="846 197 992 260">Unexpected</p> <p data-bbox="1024 197 1429 296">had to talk about the stuff that I may not have to anymore after treatment” (lines 255-257).</p> <p data-bbox="1024 338 1429 625">C: “But by the second rehearsal when we were just doing improv games, somehow I was still crying because it was hitting nerves and things that I haven’t like dealt with for a long time” (lines 152-154).</p> <p data-bbox="1024 667 1429 1066">C:” but like my mom passed away from cancer so in the script my character has a mom who like left her. So then she comes back and wants forgiveness and I have a lot of unfinished business I wish I could have said to my mom but she got sick. So Laura used that (in the play) to help me get some closure” (lines 548-552).</p> <p data-bbox="1024 1108 1429 1360">C: “I think its because we got to dip in and out of the really deep really hard, really raw, really fresh stuff that was like oh my God that’s a wound I haven’t gone to in awhile” (lines 600-602).</p> <p data-bbox="1024 1402 1429 1724">S: “But then once I was speaking to my horse who had died and I don’t even know how I got to that, but it was really had because I had to put down my horse like a month before, of 20 years. So I remember that group and how it was” (lines 184-188).</p> <p data-bbox="1024 1766 1429 1864">M: “Because all of a sudden I would start connecting to my character and the exercises and</p> |
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| | | | | <p>just allowing things to come up for me, but I would leave rehearsal feeling like almost released in a way. Like I had gained a sense of peace” (lines 105-108).</p> <p>E: “But I didn’t really expect that so much would come up, that I’d be having light bulb moments. Like light bulb moment where-I have to talk about this, look at this” (lines 251-253).</p> <p>B: “And so, it was really good for me in bringing up so much around loss and the feeling that loss brings up and the grief” (lines 313-314).</p> |
| Advancing Psychological Recovery | Cognitive Distortions | | Unresolved to Resolved | <p>R: “Being okay with myself to perform and get positive feedback or challenging feedback, and taking it as a way to improve instead of insulting” (lines 516-518).</p> <p>C: “..was like theater, like rehearsals are one place where criticism is not really criticism. Its love. Because I have a really hard time with criticism so I would deliver a line and he would be like “Okay, less goofy, more this.” And inside I was like “oh god, you were so goofy, that’s so embarrassing. It might sound silly but in my head I started going down this spiral of being like that’s so embarrassing...so I really had to learn how to take it in and not see him as saying there is something wrong with you” (lines 242-249).</p> |

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| | | | | <p>“I really had to deal with the way I take feedback...this is a play. They are not saying something is wrong with you They are saying; try to delivering the line this way, this way. They are not saying, how dare you?” (lines 257-261).</p> <p>C: “My dress was wet from the water and I felt like a mess and people were still hugging me. I tell myself the only way people will like me is if I am always okay and on and everything and looking okay. So when I was really not feeling that way and people still came up to me and were like that was so great and treated me the same way, it kind of made me address that theory” (lines 432-438).</p> <p>C: “But hearing someone else read something I wrote, having to perform it and everything, it was cool but also that part of me that thinks I’m not good enough and I’m not okay, seeing someone else take your words really seriously and deliver them really beautifully kind of like puts that voice away because its like they think that those words are beautiful” (lines 489-493).</p> <p>C: “I didn’t want someone to read it and be like I have to say this? What is this? And then I’m like I wrote that. That’s not what people said. They actually liked what I had to say. The experience with that, its like having a piece of the</p> |
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| | | | | <p>cast in the script which is really cool I think and I think every time someone said something I wrote, at first I kind of held my breath. But then by the end it was like nothing. I totally forgot. So it was nice to be able to let that go a little bit” (lines 507-515).</p> <p>P: “She came up to me after and gave me a big hug and told me I had a gift. Which feels good and I was like at the same time “Who are you? You don’t know anything! It’s my own dismissive stuff. And I got this in my feedback from other people, like my friends that came and saw it” (lines 391-395).</p> <p>V: “I don’t like to hear the critiques, but I also think that’s good because in life you’re going to hear critiques, obviously. So, again, it kind of just is desensitizing in a way” (lines 207-209).</p> <p>V: “Its really hard for me to take any compliments and to take them for their word. So I got a lot of compliments, not just from my friends, but from random people who thought I did a good job and stuff” (lines 281-285).</p> |
| Advancing Psychological Recovery | Taking up Space | | Apprehension to Embracing | <p>C: “Its hard for me to take up that much space because I had a lot of lines and people had to sit and wait for me to be done with my lines and watch me” (lines 180-181).</p> <p>K: “And it happens so fast in</p> |

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| | | | | <p>my mind that I'm not wanting to take up space. But it takes that to work with personal material" (lines 192-194).</p> <p>M: "I've always struggled with being seen. I want to be in the background more often. So Dave and Laura had me on stage, myself, doing a monologue. I benefited by exposing myself in that way and learning to be OK with it" (lines 198-201).</p> <p>M: "I think people with an eating disorder, a lot of us struggle so much with taking up space or being seen so to have to be on stage, to be in front of people and to have to own it....I speak generally for everybody, but for me that's all true" (lines)</p> |
| Advancing Psychological Recovery | Authenticity | | Obstructing to Cultivating | <p>R: "It was a lot of self discovery" (line 102)</p> <p>R: "I didn't expect all of the soul-searching" (line 137).</p> <p>C "There was something about having to update everyone about how you were really doing. It just forced me to be kind of like authentic and I was like, I would rather just talk about my past and tell them this lovely script that I've been telling everyone. So that was hard to have to be real with this group, because there was no BS'ing here" (lines 224-228).</p> <p>"I spoke to the fact that I have struggled with having like a facade on and like a lot of my</p> |

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| | | | <p>life I done a lot of performing. By that, I mean smiling all the time even when I'm hurting inside. No one knows what's going on with me because I'm really good at it. I'm really convincing so I've always thought it's kind of like everyone's my audience and I'm kind of on stage in my life so when I was really on stage and there was a real audience it was kind of cool to like tease out my life like I don't need to be performing. Performance is when you're on a stage. Like I'm in a play, I'm performing. I don't know. When I was finished with the play I was like these people in your life aren't like audience members. They're like people in your life. I've been treating a lot of people in my life like they're my audience and I have to like perform and like be on. And so when I actually perform for an audience, it was that kind of cool thing where like oh, this is really an audience" (lines 391-403).</p> <p>S: "I definitely benefited from the internal process of putting my truth out there and letting that develop as it will and letting some one else form it as it fit into the play" (lines 159-161).</p> <p>S: (referencing the performance) "It felt real, in some ways accepted as I was, like accepted for who I was and what I was doing and what I am working through and what</p> |
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| | | | | <p>my process has been. I mean there was hesitation to even invite people to the play, just because I haven't told a lot of people that I am in recovery or that I came to Saint Louis for treatment I'm kind of coming into a space where I'm telling more people" (lines 368-372).</p> <p>M: "It was like I have to connect to my intuition to be able to (play the role)." P. 6</p> <p>M: "I fell more into like a self who I really am like in an authentic way without being overwhelmed" (lines 271-272).</p> <p>P: "And I was able to say: I feel like I'm not getting what I need. By playing this character, we were able to change it" (lines 278-279).</p> <p>V: "Also, because of this, because I sang in the play, I discovered that I really miss music...and I have been thinking about more ways to incorporate music back into my life" (lines 122-124).</p> |
| Advancing Psychological Recovery | Relationship to the Body | | Functional to Instrumental | <p>C: "And then suddenly we're playing an improv game and we were using our bodies and doing things that were so hard with our bodies because we have issues with our bodies, but were still able to be like London Bridge and someone's going through and like we're able to laugh a little bit" (lines 602-606).</p> <p>C: "I think the fact that you use your body in theater...you do,</p> |

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| | | | <p>even in a role where you're standing up straight you're still using your body as a tool and you're body is a gift in the theater in a way because a lot of times I feel like this thing in the script doesn't make sense and Laura will be like 'It will make sense with acting it. Your body will explain it' I'm like, okay. And its true! So yeah, your body, I don't know if I've ever felt like man, my body, I'm so appreciative of it today. But its like you do need it when you're acting and I think when you spend so much time loathing it and then in a position where its your tool you must foster some sort of appreciation for it" (lines 631-642).</p> <p>C: "There was this one part where I'm rolling on the ground and River is on top of me and like we fell from the heavens. I think about it. I am able to roll on the ground. I don't know if I've ever felt this at this time. I'm so glad you can do this. I don't know. Its like, while you're acting you really need it (the body) so I think there are a lot of times during the day where I stop now and I'm like, I need you right now and during acting I cant imagine how you would portray something with out gesticulating, like doing something to explain it. So, I think that's the best way people with eating disorders, it helps them realize that their body is more than a shell"</p> |
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| | | | | <p>(lines 644-651).</p> <p>S: “Being on stage and the performance part of it bring body image up and body image is a hard one to step out of when that’s been like such a focus and taken up so much space its really easy to let that come back in and take up space and be a focus and it (performance) beings that right up to the forefront. There’s no getting around it. So by doing it this way, you just have to push through it and it doesn’t get its day” (lines 486-492).</p> |
| Advancing Psychological Recovery | Agent of Change | | Weak to Strong | <p>R: “And it’s a blessing to be able to perform in my opinion. It is amazing to give to the world something that was created by our different stories” (lines 400-403)</p> <p>C: “I made eye contact with the people in the front couple of rows and it was cool to see them really into it and connected and it was just a really cool, good feeling” (lines 407-410).</p> <p>C: “Everyone I spoke to and there were a lot of people that came up to me that I actually didn’t know, which was really crazy, but people were just saying how they feel everyone in recovery needs to see this and people who aren’t in recovery. I think everyone is recovering from something” (lines 415-418).</p> <p>C: “And I think from reading peoples (audience) journal</p> |

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| | | | | <p>entries at the end was so cool. I figured people would write a little think but people poured their hearts out on those pages. And I think that proves that people need this stuff. People need to be asked and have room to answer and I think this gave people an opportunity...” (lines 457-464).</p> <p>S: “We were able to touch people” (line 334).</p> <p>M: “And I’ve talked to so many people since the play that are like really identifying with this. I had people Facebook messaging me being like I don’t know you but can we meet for coffee because I really want to talk to you about how this play affected me” (lines 397-404).</p> <p>M: “Yeah so, I think it engaged a lot of people and I think that was like a gift to me as well to see that it brings more community that authenticity. I feel like I’ve been given so much in my process and ended during just the process of the play, like invested so much, for all of us to feel like I was giving back in some way was wonderful” (lines 409-413).</p> <p>P: “And they really enjoyed the play and found it funny, and powerful, and heartbreaking and exciting...and to have it kind of embodied on stage for the people to see was pretty powerful” (lines 398-399).</p> |
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| | | | | <p>“Its also cool to see the reaction of the audience when you hope they laugh- “Are they going to get it? They got it!” I don’t want people to cry, but it does mean that it hit them in a way that was profound enough that they had an emotional reaction to it. And that means we got the message across.” P. 12</p> |
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APPENDIX C: Theater Code Book

| Topic | Participant's Words |
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| <p>Theater: Distance and the use of role</p> | <p>R: "And it was very heartwarming to be that character. And I was just thankful that they thought of me in that way too" (lines 228-229).</p> <p>C: "My character was one of like, I guess if you were going to say it, one of the lead roles. And I've always struggled with being like the leading lady of my own life" (lines 163-164)</p> <p>S: "it was also really beneficial to come back and step into my character and have the experience of...so its almost like have the experience of being on the other side of like having worked through my process and made it to the other side" (lines 162-165).</p> <p>M: "There is even a point my character, at end of the play, my character comes back in and meets this community. She has been looking for community her whole life. No, that's not how it works in real life! You don't just get robbed and then you get a happy ending...I had to push myself to stay in the community to allow my character to stay there and have somewhat of a happy ending...And how that is my exact process...because I've done this play and learned this. I'm still scared but I'm going to allow my character to stay in the last scene in the community" (lines 305-310).</p> <p>B:" At first, I was really upset because my role was so different and difficult for me to play...And so, Leda, my role was everything that I've wanted but believed I didn't deserve" (lines 298-302).</p> |
| <p>Theater: Healing and connection are experienced as expedited</p> | <p>E: "It connects your deeper" (line 628)</p> <p>S: "So, I joined an outpatient group, and the outpatient group took probably three months before the group started to feel cohesive and like a safe place to bring personal stuff to it. But this gives you more cohesiveness from the get go" (lines 467-474).</p> <p>S: "It fast tracks trust, being able to trust the group a lot faster" (lines 478-479).</p> <p>E: "It's like it takes into a different dimension...it's a two and three dimensional process" (lines 609-612).</p> <p>M: "It creates so many more avenues for processing" (lines 674-675).</p> |
| <p>Theater: Performance</p> | <p>P: "We were there to create something together, which is the biggest difference I think" (lines 481-482).</p> <p>V: "And also its different because you are sharing something with people. With this, you're inviting people and to tell them whatever you decide to tell them" (lines 367-362).</p> |

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| Theater: Use of body | <p>M: “anytime I put anything in my body, like throwing the broom because my character is angry, I’m going to feel angrier more than if I was just sitting and talking about anger” (lines 663-665).</p> <p>M: “I’m putting it in my body and allowing my body to remember what that feels like when my eating disorder for so long has shut my mind off to what it feels like” (lines 667-669).</p> <p>C: “I think the fact that you use your body in theater” (line 631).</p> |
| Theater: The rehearsal process and the recovery process parallel one another | <p>R: “I remember going through the rehearsals and thinking “This is just like recovery or this is just like the play” (lines 381-382).</p> <p>E: “And it was so spot-on, that process of recovery through performance, its so spot on how it is like how recovery is” (lines 464-465).</p> <p>E: “I think that the final ending, you’re so, beforehand, heightened with anxiety and wanting to get in an extra rehearsal, because you don’t feel prepared enough, its kind of like life in recovery, right? When is it going to be the best time? You could have given four more weeks and probably we would have still said, “We’re not ready!” Because when is going to be the best time? When is it going to be the best time to be in recovery and start living your life and going through the recovery process” (lines 485-491).</p> <p>V: “If you think about it in terms of...you’re kind of just rehearsing life when you come out of treatment. So, you don’t really know how its going to go, its kind of like improving in a way, just like try things out and see what happens” (lines 230-235).</p> <p>P: “I guess in the beginning (of rehearsals) like coming into something that you really like have an idea about, but you don’t really like have a working concept of what’s going to happen.” And I think that’s similar to recovery. Everyone talks about like, ‘you need to be in recovery’ Then you get in it and you are like ‘I don’t know what I am doing!’ But somehow you stick with it; it like makes...its so cliché...but stick with recovery and you’ll make a life” (lines 325-331).</p> <p>S: “I guess in some ways its like practicing, like they say in our recovery, do the thing that feels wrong. Like it feels wrong to order the sandwich or it feels wrong to have a snack when you are in a hurry. Like doing the wrong thing and doing it anyway is what is going to take me into recovery In rehearsals early on it felt really awkward and wrong....You do what feels wrong because you’re trusting the process and you’re trusting that its going to mesh, that its going to come together” (lines 275-281).</p> |
| Theater: Touchstone | R: “Recovery Through performance helped a lot...and that is something that I can hold onto” (lines 126-127) |

| | |
|-----------------------------|---|
| Experience | <p>R: “It was so necessary for bringing (what I learned) back into my home afterwards...and that strength would help me carry on through” (lines 194-197).</p> <p>S: “Having that group, and that space, like just contact points with people has continued to be helpful till today for building relationships with people I’m learning to care about and learning to open up to. It was helpful” (lines 134-136).</p> <p>S: “So I find myself wanting to go back to old patters of presenting what I believe people want to see so that people can connect to what they want to connect to and forsake myself in doing that, but (now) not doing that, instead holding onto the space and the creation that is being open to people and I guess just doing it differently” (lines 338-346).</p> <p>M: “That specific moment was like life changing for my process. Because now every time I go into a therapy session I can be like ‘I’m going to feel this and I’m going to be fine when I leave and feel better about it. It was so good, like can we do the play everyday?’” (lines 120-124).</p> <p>M: “I never imagined I would have grown so much from doing the play. I never imagined that six weeks later I would be thinking about my character and what the next right thing for her would be or thinking about the play and everything it taught me. Its like part of my story in my recovery, in my life, in my perception” (lines 559-563).</p> |
| Discussion: Facilitation | <p>E: “Having someone come in and guide you, direct you, witness you, push you, encourage you, that throws in a really cool effect in relation to everything (you are working on in recovery) (lines 416-422)</p> <p>E: “But it wasn’t like a therapist, it was like a leader. It was someone guiding us” (lines 614-615).</p> <p>V: “I felt like it was really helpful just having Laura there” (lines 90-91).</p> <p>P: “Laura is a badass teacher and she knows it” (line 635).</p> <p>M: “I think the great thing about Dave and Laura was, they like came in with the script and then I wasn’t connecting to my character and then they sent me off with two other people and they were like, “re-write your monologue until you connect with your character, complete freedom” (lines 176-183).</p> <p>M: It wasn’t like a director, you’re on stage with your lines, read a little louder, a little softer, it was like ‘when have you felt this way before?’ And how does this connect to your character?’ Say the line 10 different times and see what feels right or you because this is your character, your story, and just pushing us to really really connect or feel whatever we felt that character would feel” (lines 261-267).</p> |

M: “I think the space they allowed for us to change our characters really opens up for that connection to happen” (lines 286-287).

M: “And Laura kept being like ‘its up to you, whatever you want to do. Thinking about it now that was huge changing my process and empowering” (lines 332-334).

M: “Laura had asked us ‘what question do you want to ask the audience? So I had been the one that was like, I want to know what the hardest thing about embracing their own humanity is. She was like, that’s a great idea, lets do it” (lines 484-487).

M: “I would be like ‘I don’t want to tell you what I wrote. But then I was like ‘Its Laura’ there couldn’t be a safer person” (lines 526-528).

M: “And she had me improv it by pretending to be a unicorn who had pretended to be a horse. And I was so angry in that moment. I don’t feel comfortable and you want me to act like a unicorn in the middle of the room? But she pushed me. She was like, ‘how would a unicorn stand?’ I was like what? I want to leave. I cannot believe you are asking me to do this. Eventually, I did it and everybody was silent and was really moved by it (lines 608-615).

C: “Oh something else that was interesting was seeing the way that Laura and Dave interacted like partners on this project. I think it was really healthy because they were not always like ‘Do you like this idea?’ ‘Yeah for sure, go for it!’ It’s not at all like that. There were times when Dave was like “I don’t like that” and Laura was like “I do” and he was like “I don’t. I don’t think it works.” And she was like “I don’t know, I think we should try it.’ And they’re like “okay” I was like, oh, they are not fighting, they are like dear friends and this is okay. Because I avoid confrontation or I rarely speak like I don’t want to rock the boat so like in friendships if someone’s like ‘I don’t like that’ sometimes I go ‘yeah, that’s fine’ even though, no, I do like that. So seeing how they interacted and they were still totally respectful. We’re like disagreeing about things and that helped me see that’s a normal way of having a friendship. That was just something extra too.” P. 7

C: “Yeah I think at the beginning like, Laura really held our hands through it and not like in a babying way. We showed up and we started right away but she was really like leading. She was saying we are going to do this, now we are going to do this. And yeah, even though she was the leader all the way through and that she helped break things down and everything, by the end we were really kind of rocking it on our own. She would be working with people on one thing and we would go work with people on another thing. Its like she kept giving us more and more space and taking more ownership of the project (lines 343-355).

C: “And I think we spoke with Laura about it is really important that the person leading it, they need to be a special kind of person and that might be asking a lot. You cant throw any counselor in there, even if you have a social work background or whatever it is, you cant just throw someone in there. ...Like I said, at the

beginning of this experience the person is sort of like a mother hen and everyone is following And then by the end its like okay you can do this and go out on your own” (lines 694-702).

C: “I think she was that perfect in between, still commanding. She’s still the leader but also she was one of us and never treated us like we were less than” (lines 702-704).

R: “I knew Laura’s talent and just her raw energy and raw outlook on just everything and her presence is just so worldly. Because she just creates this space for healing” (lines 168-170).

R: “I call them, you know, leaders, Dave and Laura, they were very supportive, they were very kind and compassionate they challenged us appropriately, there was no shame whatsoever” (lines 277-279).

R: “And just seeing them (Dave and Laura) go up and do their bit...I just couldn’t wait to see how they interacted; it’s always a hoot. They are great together, The talent and raw energy that just emanates from them. Is unbelievable and it carries the people around. And they created something for us based on what we created with them, so it was just really cool to see what came together on stage based on our stuff with their help” (lines 299-304).

R: One thing I wish was different was her (Laura’s) assistant. This person didn’t quite understand the eating disorder. And I understand that this person was currently in school and everything, but it was clear there was a lot of misfiring, a lot of concepts that weren’t perceived or even that she stopped to think about before saying something that would be, at times, detrimental to the process” (lines 479-482).

Appendix D: Twin Falls Script

Twin Falls

Act 1: The Façade

Lights up on a roman fresco. In the middle are twin goddesses-fraternal twins, standing on two theater blocks, both draped in beautiful togas. In their hair are laurel wreaths. At their feet reclines a handsome man, also in a toga, holding a goblet of wine and a platter of delicious organic fruit. Around his head a crown of grapevines and clusters of grapes. On either side are two more beautiful goddesses, each in togas both holding hand mirrors, which the twin goddesses stare into. On each of the edges of the stage tableaux are two athletic goddesses: one has a tape measure wrapped around her waist and across her chest, the other is flexed holding golden barbells, one in each hand.

Plastino: Long ago

Athleta: In the past

Sportiva: Long long ago

Plastino: Long ago in the past

Handmaiden 1: In the past

Handmaiden 2: In the past

Sportiva: In the past

All, but twins: The gods were perfect

Twins: No matter what, things are perfect

Plastino: And, there is wine. So much wine.

Twins: And that's just perfect.

Athleta: And food...delicious organic, gluten-free, dairy-free, low carb whole food

Sportiva: To keep us "healthy"

Mirror handmaidens together: And always beautiful

Twins, together: and it's just perfect.

Plastino: Long ago, in the past, there were twin goddesses.

Twins, together: fraternal twins!

Plastino: They were royalty among the gods. Everyone took care of them. Not because they were beautiful, although they were...

Twins, together: thank you!

Plastino: not because they were perfect...

Mirror handmaid one: though you certainly are.

Mirror handmaiden two: Indeed.

Twins, together: Thank you!

Plastino: and not because they were perfectly in control of everything that happened. And everything that anyone thought about them.

Athleteta: though you certainly are.

Twins, together: thank you!

Plastino: but simply because they were daughters of the God Ed

Athleta : Ed, the all powerful!

Sportiva: Ed, the soothing!

Salvia: Ed, the perfect father!

Sylvia: who loved the perfect mother!

Handmaiden 1: Ed, the all knowing!

Handmaiden 2: Ed, the god of secrets!

Plastino: but--- Ed the God did have a secret. Though his daughters didn't know it.

Pause

Long ago, one dark night his craving overtook him.

Athleta: He went down to earth, he couldn't stop himself

Sportiva: and he saw a beautiful girl, a human.

Handmaiden 1: not a goddess at all, but a human!

Handmaiden 2: Vulnerable, naive, soft, and human. Really human.

Twins: what happened?! What did he do!?

Plastino: The woman was in pain, and he showed up and whisked her away, and brought her here, and made her a goddess queen.

Twins: Our mother?!?!?!?

Athleta: You're only humans!

Sportiva: They are only human?

Handmaiden 1: nothing but humans!

Stevia opens her journal and reads

Stevia: That fall was so scary. I don't feel like I can go on. But I have to. I have to risk everything and trust that it won't go to shit. I'm terrified. I'm literally on a cliff and its crumbling around me and I need to jump to the other cliff—but I'm not sure its any safer and it might crumble after I land on it—or I might not even make the jump at all. I want to go back to dad.

Sylvia: Well...you're not literally on a cliff...

Salvia: Shut up. What did you write?

Sylvia: Its so different here. Everything is dark around me. I feel the darkness closing in. What was once clear is now hazy, muddled and distorted. This place is nothing like home. I don't think we can stop here. We might sink. It all came crashing down around me. We have to keep moving.

Salvia: That's so good. It's better than mine.

Sylvia: No its not! Yours is better.

Salvia: No yours!

Sylvia: No!

Salvia: No!

Sylvia: No. YOURS!

Salvia: What are we going to do!!! *She drops to her knees, fists hit the ground.*

Sylvia: I don't know. But lets keep moving. I can't just sit here with your feelings

Salvia: Or yours!

Sylvia: Fine. Or mine! Lets go.

They start walking.

Sylvia: Left right left right left right

Salvia: Fine! Ugh!

Sylvia: Left right left right

Salvia: I get it. Ok. *Rolls her eyes*
They come to a street corner

Sylvia: Stop

Stevia: what is it?

Sylvia: it appears to be some kind of ground made of blackness and fifth.
This small cliff seems to separate us from it. But I see there is another cliff on the other side, there by that blinking light.

Stevia: the yellow one?

Sylvia: well..yes..but now its red. Come on.

We hear horns. Loud. The twins scream. And run to the other edge of the stage. They are frazzled and overwhelmed from the traffic. They are now in front of a pushcart of food. There is water, snacks, fruit, etc. It says Ms. Waits Yums Yums. Ms. Waits is on the backside of the cart stocking the shelves and or sweeping.

Salvia: I'm feeling something.

Sylvia: What?

Salvia: I don't know. It's just...something big...in my stomach.

Both: Journal!

They take out their journals and they pause and they are stuck.

Sylvia: *getting angry.* It's not working! It's not enough.

Salvia: It always works. We've always journaled since we were kids and it's always worked.

Sylvia: Yeah. Well. It's not working now. Whose idea was journaling anyways? *Grabs the box of hostess cakes.*

Salvia: What are you doing?

Sylvia: I don't even know...but it feels like eating this will make me feel better.

Salvia: Well gimmie one too.
They open the boxes

Ms. Waits: Excuse me, but you haven't paid for that yet!

Sylvia: What do you mean?

Ms. Waits: Money. *With sarcasm* Ever heard of it?

Sylvia: No.

Ms. Waits: *more sarcasm, with some rudeness* Well I don't know where you're from, but here on planet earth, when people need food. They pay for it.

Both: EARTH! We're on earth!!!

They start off excited, they have figured it out, yelling, jumping, celebrating, and then it turns to panic and anxiety, 'holy shit we are on earth—what are we going to do?!'

Salvia: This is terrible!!

Ms. Waits: Yeah, no shit. Welcome to my world. That's life in the big city for ya.

Sylvia: I don't like it here. It's nothing but pain, loud noises and missing home.

Ms. Waits: I know what you mean. I'm not from here originally. Where I came from it use to be either sunshine and rainbows or complete and utter shit. For the longest time I thought that people were either good or bad and ideas were either right or wrong. There was no room for negotiation. A favorite motto of mine was "go big or go home." So I came here, to the big city. It was such a shock when I landed here, you know? I honestly figured the city would be either heaven or hell. Floating among fluffy white clouds or dodging pits of lava. But no. Its not black or white here. Its grey. The duller shade of fucking grey. Its funny, people spend their entire lives being saints to avoid not ending up in hell. But to be frank with you. I think the in between is worse.

Sylvia: Well that sounds terrible.

Salvia: Why would anyone want to ever be here?

Ms. Waits: Ah, well, you can't change the past. This is where I ended up.

Sylvia: Can you change the future?

Ms. Waits: Maybe.

Salvia: Good. Please change ours.

Ms. Waits: Are you two sisters or something?

Salvia: We are! Twins.

Ms. Waits: you don't look like twins

Both: Were fraternal.

A street urchin teen, Ursaline, enters in, she licks her lips. She's hungry and desperate.

Ms. Waits: Oh that's a surprise. Life is full of surprises, that's for sure. Guess that's one thing about life in the big city.

Here... Gimme those boxes back. Take these.

She hands them each a bottle of water, then an apple and each a cupcake.

I don't know if I can change the future. But maybe this will make your day a little easier.

Ursline: Oh, hey. I'm with them, too. Can I have some?

Ms. Waits: Oh, well..sure.

She turns around to get another bottle of water. The street urchin grabs arms fulls of food and yells

Ursline: Run!!!!

The girls are confused, panicked and afraid so they run.. Ms. Waits is alone on stage.

Ms. Waits: Stop! Not again. Damn it. I'm exhausted. I took a risk by reaching out and this is what happens. I'm risked out. I want to be brave and connect to people, but instead I find myself tired and worn down. Maybe I'm better off alone. I should stop chasing after people and connection because more often than not once I catch them, I find myself compulsively caretaking them anyway. I won't talk about my feelings or me. I fall into a black hole and I don't exist. Maybe I should stop and I'm tired of chasing them anyways. I wish I could find my home.

Blackout

Act 3: Finding yourself, finding others

Sound of sirens as they past through. Lights up on the three.

Ursline: That was awesome!!! How was the party?

Salvia: Excuse me?

Ursline: Aren't you dressed up for a costume party? How are drunk are you?

Sylvia: Were not drunk.

Stevia: Were twins.

Ursline: You don't look like twins...

Both: Fraternal!

Ursline: You're going to a fraternity party? Can I come?

Stevia: Ok!

Sylvia: We don't know where we are going.

Ursline: Me neither. But I know I'm not going back there.

Sylvia: Wait—did you just steal those?

Ursline: Yeah. So what. I'm homeless and broke.

Sylvia: Yeah, well, we're homeless and we don't steal.

Ursline: Well its different. I was thrown out of my home.

Salvia: Well, we were too. And we don't steal. Come on Sylvia, lets get out of here.

Ursline: Fine with me. Do whatever you want. I'm gonna be a big ol' star in Hollywood one day and you'll see my name in lights.

Salvia: So what

Sylvia: We are goddesses!

Stevia: Real goddesses.

Ursline: Yeah, then snap your fingers and make all my dreams come true.

Sylvia: Why should we?

Before she can answer Stevia jumps in and snaps her fingers.

Sylvia: *(under her breath)* Or...were anyway...

Ursline: Nothing happenin' Look like mortals to me.

Sylvia: Shut up!

Sylvia pushes Ursline, she falls

Urslime: Ouch!! Owwww!!!

Urslime starts to cry. Sylvia and Salvia pause. They remember their fall. They step back. They drop to their knees.

Stevia: That's pain, isn't it!

Urslime: Leave me alone! Leave me alone!!! What kinds of goddesses are you? Leave me alone.

Sylvia: Its hurts, doesn't it? I'm so..sorry...I'm sorry!

Salvia: I'm sorry, too!

Urslime: Just leave me alone!

Salvia: No. You are a star.

Urslime: No I'm not. But ...I will be. Just wait, you'll see!

Salvia: Show us.

Sylvia: We wanna see you.

Urslime sings her song, she's nervous at first, but gains confidence as she goes and sings and acts the shit out of the number. As people walk by they give her money. The song is heart breaking, beautiful, and hopeful, the twins are moved.

Salvia: That was amazing!

Sylvia: So beautiful.

Urslime: Thanks. When I sing, I forget for a moment all the hurt in my past and I just feel like the real me, ya know?

Sylvia: I know what you mean...but to be honest, I'm not even sure who the real me is anymore...

Salvia: Me either. Or what it means to be real... So, what is all this stuff people put here?

Urslime: Holy shit!!! That's a lot of money!

Sylvia: You could pay back Ms Waits!

Urslime: Why would I do that when I can finally make it out of here?

Stevia: It's a different kind of feeling. Because when I pushed you, I remembered when people pushed me. And it made me feel terrible. But being with you now. I just feel....connected...

Sylvia: You should try it.

Urslina: I'm used to being pushed around and I'm pretty good at being alone and disconnected. Why would I want to do something so difficult? I'm still having trouble at seeing the possibility of a life with out sacrificing parts of what I want and need. I'm scared, but I guess...I'm willing to try.

They hold her hand or embrace. It is quiet for a moment.

Salvia: Good luck

Urslina turns to walk away

Sylvia: Hey, wait! What's your name?

Urslina: Urslina. My name is Urslina.

Sylvia: Good luck, Urslina.

Stevia: I believe in you.

Urslina: Me too.

She exits.

Act 4: Foraging ahead

Twins: Journal!!!

Salvia: I'll go first! People can come together and be so creative and energetic and inspiring! It will take practice for it to become second nature but I'm going to challenge myself. Ok, You read yours!

Sylvia: This is hard. It's different here. But I am still happy I'm pushing through, even though it's taking everything in me to not run away. But honestly, I wouldn't want to go back to my old life anyway. How could I go back to a perfect world knowing what I know now?

Stevia: You wouldn't want to go back to our amazing life? Aren't you missing being perfect! It was so perfect!

Sylvia: Was it? I can't even remember any more if that is true. The more I start to feel pain and connect to people and be in this world, it like I am waking up for the first time. It feels so hard. But something about being here feels right. I feel...alive.

Belle: Hey, Why are you guys dressed like that? Do you know Darrell? Looks like his style. You better watch out for that guy, he's not who he says he is.

Sylvia: Is anyone?

Belle: Hey, What are you guys doing out here? Are you working with Darrell?

Stevia: Darrell???? No.

Sylvia: Never heard of him.

Belle: You sure? Dressed like that (?)... looks like his style. You better watch out for that guy, he's not what he says.

Sylvia: Turns out, nothing is.

Belle: You're telling me. Get this, awhile back, I answered an ad for a 'street worker'; I was excited to finally use my degree in social work. So, the "boss" Darell told me to stand here, on this street corner. He said it was the best corner in town and had a pretty interesting dress code for the job. I should've known something was off. I wasn't sure what was great about it; it's a janky area if you ask me. But the people seemed nice; I thought I'd be able to help some of them. A lot of guys driving by that'd roll down their window and ask how I was doing, a few even asked how much? I'd just wave, "Doing great. Thanks for asking!" They always looked confused especially when I'd offer to tutor them or help with employment, stuff like that. Then some nun handed me a bag full of individually wrapped, colorful, weird-shaped balloons: "God bless and be safe"? Were they magical or dangerous of something?? Were for me anyway, I'm allergic to latex.

Darrel told me I had to remember to ask people their name. When I realized it was a phony ad in the paper, it was too late. Now I make sure that creep isn't tricking others. I watch this street like a hawk. I'm Belle, who are you?

Sylvia: I'm Sylvia

Stevia: I'm Stevia

Belle: Are you guys twins?

Both: Yes!

Belle: Fraternal, right? No judgment but... your outfits come off as provocative, *especially* 'round here. Are you sure Darrell didn't send you... you can tell me, it's ok.

Sylvia: We don't know anything. We're just trying to get by. I guess we'd do anything to survive.

Belle: You can make it without Darrell or the like. There are other ways.

Stevia: We're not from here.

Belle: I'll protect you. I know my way around nowadays. I had some bad things happen to me, but I'm smarter now and care a lot it doesn't happen to others. I lost time in a haze of fear and avoidance getting out of some tough shit, then I just felt desperate and hated myself for it. I didn't want help from anyone, I was like an island of a person. I don't do that any more. I found some really good people. I'm not afraid of living today or trusting the good in people. I can help.

Sylvia: How do we know *you're* good? What if you are just working for this Darrell guy or someone else? Nothing on Earth seems trustworthy.

Salvia: But she wants to help us. (quietly, pleadingly to Sylvia)

Belle: Look, trusting someone is scary at fist, sometimes terrifying, makes you want to crawl in a corner and hide. You don't have to come with me today, but I'd like to show you where I found help when I needed it. I saw what you did for that homeless girl. It takes guts to do what you believe is right, a lot of courage to listen to your heart and trust yourself. Life only gets harder when we push all the people away. There ARE good people around, like yours, that want to help, nothing more.

Stevia: Come on, she's right...we have nothing; nowhere else to go. I'm tired.

Sylvia: Ok, lead the way

OR... just the last bit:

...There ARE good people on Earth, people like you, that want to help, nothing more.

Stevia: but... people?... *we're* people?! (just to Sylvia, sinking in) She's right, Sylv, we have nowhere else to go, we need help.

Sylvia: Ok, lead the way.

Lights cross fade to other side of the stage. Ian is standing there. He runs an animal shelter and he is getting ready for dinner. he starts by bringing on a table and a few

chairs. He goes back and gets a dog. And brings the dog out and starts to brush him. The moment the dog sees belle he barks and runs to her.

Act 5: Feeling and finding yourself.

Belle: Hey Troy. I found two more strays.

Troy: No problem, There's always room for more.

Salvia: Were not strays, were twins.

Sylvia: I can't believe you brought us to an animal shelter. We may not be goddesses but at least were human.

Troy: You don't look like twins

All three: Fraternal.

Troy: Oh got it. Well I found a "stray" too. This is Ms. Waits.

Ms. Waits: I was really down on my luck and at my wits end and then I unexpectedly found money and a note saying, "I feel terrible for stealing from you, I know you were just trying to help and I took advantage of it. Please don't give up on the world, there are good people out there"

Troy: I was out on one of my daily dog walks and ran into Ms. Waits who told me her story. I was so moved that I shared my story...

Salvia: Sylvia!

Sylvia: shhh! Go on.

I was an only child growing up. A few years ago my mother passed away unexpectedly. But she always told me to follow my heart. At the time I had my best friend, Jupiter, a golden retriever mutt who was with me my entire life. However, he died around the same time my mother did. I was left alone, to live with my uncle and aunt. They weren't well off so I had to help in any way I could. I started working with my uncle at the factory nearby. Factory work was difficult. During my lunch breaks I would eat out on the railroad tracks. There was always a stray dog that would be outside meandering about looking for scraps. And every lunch break, I'd give half of my sandwich to a very eager and happy canine. I didn't know it at the time but within the next couple of weeks, my life would be forever changed.

Salvia: Sylvia!!! Its-

Sylvia: Shhhh!!!!

Ian: You may call it sheer luck or God's touch or the universe picking me back up, but nothing would ever be the same. You see, on my 21th birthday, my uncle gave me a lottery ticket as my gift. A few weeks later, on my way to work, I passed the newsstand and saw that the winning ticket for 150 million dollars went unclaimed. Curiosity nagged me to take a look at my ticket and sure enough, I became the richest person in my town. I begged my uncle and aunt to take the money as gratitude for taking me in after my mom died. But they wouldn't have it. So, I followed my mom's advice and I opened this animal rescue facility. With several volunteers, including my aunt and uncle, I set out to complete my life's work by helping as many dogs, and cats that have been left without a home and unloved. But I learned there are just as many people who need the same thing. So everyone is welcome to make a home here.

Stevia: It was me!!!!

Sylvia shakes her head

All: What?

Salvia: (kneeling and takes his hand) I know this sounds crazy. But I'm the reason you won the lottery. I'm actually a goddess...or was a goddess. I watched you from above grieve, work hard, have courage, have fun playing with animals, being kind and be genuine and I wondered. What must that be like?

Ian: Come look at my place and Ill show you.

During this exchange a beautiful and mysterious woman has begun to set the table for dinner. She smiles when Ian takes Salvias hand.

Lita: So, that's two extra plates for dinner.

Sylvia: I'm not sure I'm staying

Belle: Ok. I understand. You're free to go. But I want you know, this is a safe place. And if you choose to. You can make it good here.

The three of them exit.

Lita: This is a good place to be. I came here with nothing. But I found myself.

Sylvia: Well I've got worse than nothing. I lost everything. I was thrown from my home. Chased through the city, Scared and desperate. And now I might even loose my sister, at least that's what it feels like anyway.

Lita: I know something about loss. Many years ago, someone loved me so much; he came into my world to get me. I was sick, but I was also in love and ready to fight for this person. He helped me make a plan for my future; to return to my world he comforted me when things felt too much, he held me up when I could no longer stand. Until that

connection became my burden and his hold on me became my crutch. I thought that as long as I did what he said was right, I would be fine, but I wasn't. I would be fine, but I wasn't. And his love wasn't enough to hold me up any longer. Love can't save you from your pain. It can help, but it can't be the only thing that you have. Eventually, you will need more. *She takes out her journal* I wrote the story here so I would remember it.

Sylvia: and you had two beautiful daughters...but you lied to them. And you left them.

Lita: I did. But I didn't lie.

Sylvia: you gave them a journal and left them alone and disappeared. They needed you.

Lita: No, I was sick. I did my best. I loved them and I never stopped.

Sylvia: But love is not enough. You just said, love is not enough. But you fell and then they fell.

They fell and they hurt, and they suffered. Fuck you.

Lita: I know. I'm sorry. It's ok that you are angry with me.

Sylvia: But you weren't there. You weren't there when everyone fussed over me and you weren't there when everyone turned on me. And I took care of Stevia. I did. That wasn't my job. I had to get us through it. You weren't there.

Lita: I'm here now. And you're here too. I'm sorry.

Sylvia: How can you say that? Being here doesn't make up for it. You think I'm sorry is suppose to be enough?

Lita: No, there's still a lot of work ahead us. I want you to know, I found people who cared so much that they stay here to be with me, they didn't push me back up, and they didn't try to save me. They listened to me and talked things out. They asked how they could help and were there when I needed them. I may not have had someone to love me. But I had many who cared. And they aren't my crutch, because I don't allow them to be. I knew I needed to get out. I could no longer rely on your father and that other world to save me. I needed to get out for me. And if you want, you can stay here and do the same. I hope you do.

Sylvia: Can I help you set the table?

Lita: Are you going to break the dishes?

Sylvia: I might. I'm really mad.

Lita: That's ok. There's more in the kitchen.

They set the table as the lights fade

Appendix E: Informed Consent



Informed Consent for Participation in Qualitative Research Interview

Participant _____

Principal Investigator _____ Laura Wood _____

1. You are invited to participate in a research study conducted by Laura Wood. The purpose of this research is to explore the experience of individuals who participated in the Recovery Through Performance Theater Project.
2. Your participation will involve:
 - ❖ Completing a short questionnaire requesting demographic information on you.
 - ❖ Participating in interviews with the researcher, post your performance experience. During this interview, you will be asked to respond to questions regarding your experience in the Recovery Through Performance Theater project.

The researcher may contact you after the interview by telephone, email, or personal visits to answer follow-up questions regarding this project. The purpose of the follow-up interview is to help clarify interview data.

3. The total time commitment, including follow-up question contact, is not expected to exceed 1 hour. There will be no remuneration for your participation in this project.
4. You may benefit by discovering more about yourself in the process of answering questions about your performance experience. Participation will contribute knowledge about life in recovery for clients with eating disorders.

5. There are no anticipated risks associated with this research, minimal risk may include that you might experience emotions in speaking about the project that you were a part of. Though not anticipated, should you find yourself experiencing overwhelming emotions, resources will be made available for further support. Your participation is voluntary and you may choose not to participate in this research study or to withdraw your consent at any time. You may choose not to answer any questions that you do not want to answer. You will NOT be penalized in any way should you choose not to participate or to withdraw.

6. Your interview will be tape-recorded by the interviewer. By agreeing to participate, you understand and agree that your data may be shared with other researchers and educators in the form of presentations and/or publications. In rare instances, of researchers study must undergo an audit or program evaluation by an oversight agency (such as the capital Office for Human Research Protection). That agency would be required to maintain the confidentiality of your data. In addition, all data will be stored on our password – protected computer and/or in a locked office by the research team. Voice recorded data will be destroyed one year after the completion of the final manuscript associated with this research.

7. If you have any questions or concerns regarding this study, or if any problems arise, you may contact the primary investigator, Laura Wood at lauraleighwood@yahoo.com . Though Laura Wood works for Castlewood Treatment Center, this research is not affiliated with Castlewood Treatment Centers or affiliates in any way and has no liability in regards to this research.

I have read this consent form and I have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I consent to my participation in the research described above.

 Participant's Signature

Date

Participant's Printed Name

 Signature of Investigator or Designee

Date

Printed Name