

Healing Through Attunement:
Adolescent Eating Disorders and Family Dance/Movement Therapy
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Abstract

This thesis addresses the patterns of communication and boundaries within the families of adolescents diagnosed with eating disorders. Using aspects of Attunement, the Kestenberg Movement Profile, and Laban Movement Analysis, dance/movement therapy (DMT) can support the family using a body-based and primarily non-verbal method of treatment. Clinical application of the material is discussed.

Keywords: attunement, boundaries, dance/movement therapy, eating disorders, family therapy, Kestenberg Movement Profile, Laban Movement Analysis

The first formal diagnosis of anorexia as a medical condition occurred in England in the 1680's when Dr. Richard Morton described his 20-year-old patient as "a skeleton clad with skin." He suggested that her sadness literally ate her away (Engel, 2000). In 1873, a physician to England's royal family was the first to characterize anorexia as a disease separate from religious hysteria or biological eating problems. He believed that the disease arose from mental issues, but patients should not be treated as mentally insane. He later named the illness anorexia nervosa, meaning "loss of appetite" (Engel, 2000). Around that time, French psychiatrist Charles Lasegue described anorexia from a social and psychological view, emphasizing the role of the family. He believed that anorexia could only develop in homes with an abundance of food, where children were expected to finish everything on their plates, leading to stress at mealtimes. He believed that some children refused to eat as a form of rebellion, while some women protested by not eating to display emotional distress (Engel, 2000). Unlike anorexia, cases of bulimia were not medically reported until the early 1900s, when French psychiatrist Pierre Janet describes a woman engaging in secret compulsive binges.

Today, at least 30 million people in the United States suffer from eating disorders, and up to 70 million people suffer globally (NEDA, 2016). The Eating Disorders Coalition reports the number of females suffering from anorexia to be up to about 3.7%, while the percentage of individuals with bulimia nervosa could be up to 4.2% and the percentage of binge eating disorder at 5% (Costin, 2007). Eating disorders affect all ages and genders, but roughly 90% of those diagnosed with anorexia nervosa are adolescent females (Costin, 2007). Anorexia nervosa is stated to be the most fatal of any psychiatric illness, with a significant risk of death and suicide. The mortality rate associated with anorexia nervosa has been reported to be twelve times higher than the rate of all causes of death for females aged fifteen to twenty-four years (Costin, 2007).

Eating disorders are patterns of disordered eating behaviors accompanied by underlying psychodynamic, cultural, and gender conflicts (Krantz, 1999). They are body-based illnesses marked by a variety of unhealthy eating and weight control habits that become obsessive, compulsive, or impulsive (Costin, 2007). The three main types are anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). All develop in adolescence or young adulthood, across cultures. Three essential features of anorexia nervosa include restriction of food (energy) intake, intense fear of weight gain or behavior that significantly discourages weight gain, and disturbance in self-perception of weight or body shape (American Psychiatric Association, 2013). Anorexia nervosa restricting type is characterized by weight loss primarily through dieting, fasting, or excessive exercise, while anorexia binge-eating/purging type is characterized by the individual engaging in recurrent episodes of binge eating or purging behavior. In individuals with anorexia, weight loss is perceived as an impressive achievement and a mark of self-discipline, whereas weight gain is perceived as a failure of self-control. Three essential features of bulimia nervosa include recurrent episodes of binge eating, recurrent compensatory behaviors to prevent weight gain, and perception of self excessively influenced by weight and body shape (APA, 2013). Binge eating and inappropriate compensatory behaviors must occur at least once per week for three months to qualify for a diagnosis. An episode of binge eating is defined as eating an excessive amount of food in a discrete period of time (less than two hours). An additional binge eating episode criterion includes a sense of lack of control during binges, or an inability to refrain from or stop eating. Some individuals describe a dissociative state during or after binges. Inappropriate compensatory behaviors, referred to as purging, include vomiting, misuse of laxatives and diuretics, fasting, and excessive exercise (APA, 2013). The essential feature of binge-eating disorder is recurrent episodes of binge eating

that occur at least once per week for three months. While similar to bulimia nervosa due to the occurrence of binges, individuals with binge-eating disorder do not display the compensatory behaviors. Binges are also characterized by marked distress and are associated with eating rapidly, eating until uncomfortably full, eating when not physically hungry, or feelings of disgust or embarrassment after a binge (APA, 2013).

Increasing the severity of eating disorders, many medical complications are caused as a result of these behaviors, ranging from hypothermia and hair loss to esophageal rupture (Costin, 2007). Osteoporosis, pancreatitis, severe dehydration resulting in kidney failure, and abnormally slow heart rate and low blood pressure leading to a high risk of heart failure are also reported. Due to these health risks, eating disorders can be life-threatening (NEDA, 2016). Individuals with eating disorders may exhibit self-cutting and self-harming behaviors. Psychiatric comorbidity is not uncommon, with individuals with anorexia and bulimia diagnosed with anxiety disorders, depressive or other mood disorders, body dysmorphic disorder, and personality disorders, such as borderline personality disorder. Individuals with anorexia are more likely to have social phobia or obsessive-compulsive disorder (OCD), with behaviors related and unrelated to food (Costin, 2007).

Eating disorders are complex conditions that are affected and caused by a variety of factors. Risk factors are biological, psychological, social, and interpersonal. Although a clear biological cause has not been found, there is evidence to suggest certain chemical imbalances responsible for appetite and digestion contribute to the development of eating disorders. Psychological factors include low self-esteem, feelings of inadequacy, depression, anxiety, anger, stress, or loneliness (NEDA, 2016). Social factors include cultural pressures that glorify certain body types and stress related to racial, ethnic, gender or other forms of discrimination.

Interpersonal factors include troubled personal relationships, history of being ridiculed based on weight, or history of physical or sexual abuse (NEDA, 2016). However, these various factors were not understood until recently.

Anorexia and bulimia were originally thought to be physical diseases due to a medical condition, often hormone imbalances or endocrine deficiencies. At one time, physicians believed anorexia to be a form of tuberculosis. It was not until the 1930s that the wider medical community began to view eating disorders as part psychological and emotional rather than wholly physical. As recently as the 1970s and 80s, eating disorders were thought to be mainly caused by cultural factors, including pressure to be thin and diet fads. The focus of treatment during this time was simply willing the patients to eat, a process called refeeding. In the 1990s, binge eating disorder was recognized as a formal disorder separate from emotional overeating or food addiction (Engel, 2000). Starting in the 1980s and continuing to today, research has become focused on the multidimensionality of eating disorders. In doing so, new causes and risk factors have been discovered, leading to a multi-dimensional approach to treatment.

Eating disorders can be triggered by significant events or situations that cause an individual to feel vulnerable (Kleinman, 2009). It is no question then why the majority of individuals with eating disorders are adolescents. The period of adolescence is a time of intense change, which can bring a great deal of stress, confusion, and anxiety. This period brings about a physical transformation, often accompanied by feelings of self-consciousness, low self-esteem, and hormonal changes affecting the individual physically, emotionally, and psychologically. New social pressures emerge concerning body image and romantic or sexual relationships. Adolescence brings about many changes in a short period, causing an individual to feel ill-equipped or overwhelmed in dealing with their new inner and outer state (Eating Disorders

Victoria, 2017). The eating disorder can act as a coping strategy for the adolescent to regain control when their environment becomes chaotic (Herman, 2002). Eating disorders are not about control of food, but about control of emotions, with individuals using food as a substitute for emotions. In this way, eating disorders are considered “adaptive disorders” because they form as an individual develops in their environment (Kleinman, 2009, pp. 127). Due to a lack of healthy coping mechanisms, an adolescent relies on an eating disorder to help them adapt to their environment. The eating disorder is doing the opposite, preventing the adolescent from experiencing change and replacing the necessary skills to react to and communicate with their environment.

The environment begins with the family. An adolescent cannot be seen as a singular force, as a large part of their identity is formed within the context of their family, as explained through the family systems theory. Family systems theory is a theory of human behavior that views the family as an emotional unit and uses systems to describe the complex interactions in the unit. Under the assumption that members affect each other’s thoughts, feelings, and actions, families are viewed under the same “emotional skin” (Kerr, 2000). Members solicit each other’s attention, approval, and support while reacting to other members’ needs, expectations, and difficulties. A change in one member’s functioning is predictably followed by changes in the functioning of others. This interdependence varies between families, but under the family systems theory, it is always present. Family emotional interdependence is believed to have evolved to promote the cooperation required to shelter and protect members (Kerr, 2000). However, heightened tension can intensify processes of unity and balance. For example, when family members become anxious, the anxiety spreads within the unit, making the emotional connectedness stressful rather than comforting. To reduce tension, certain members may

accommodate by taking responsibility for the distress, literally “absorbing” the system’s anxiety (Kerr, 2000). These members then become the most vulnerable to problems such as eating disorders.

The family system plays a key role in the adolescent’s development. Through interactions within the family, the “wider cultural context” is defined, and values are established (Haworth, 2000). The family acts as a mediator of culture by transmitting messages about thinness and body shape. Based on these values, adolescents explore identity and develop their concept of self and self-image. Through interactions and examples, individuals develop a healthy or distorted body image within the context of family life. The Annual Review of Eating Disorders reports that among preadolescent females, family pressure to be thin affects body dissatisfaction more than pressure from the media or peers (Costin, 2007).

Skills of communication are also learned through the family system. Families model emotional expression, expression of needs, and conflict resolution. When communication is limited or discouraged, there is a greater risk for an eating disorder to develop to serve as the indirect communication by causing a physical crisis (Cooper, 2008). It is common for an adolescent with an eating disorder to display alexithymia, or difficulty expressing and communicating feelings or needs (Kleinman, 2009). However, alexithymia has also been found to be a common trait in the families of eating disorder patients. When open and honest communication is not present, full emotional expression can be impossible, leading to blame, hostility and mistrust between members. When communication is discouraged or misinterpreted, there can be a lack of comfort and safety, leading an individual to seek comfort through dangerous means (Cooper, 2008).

Research suggests that a certain pattern of behaviors concerning boundaries is common in the families of eating disorder adolescents. Boundaries are physical and emotional barriers that exist to distinguish self from non-self (Schwartz, 2007). These patterns are found to disrupt the individuation process of child from parent, not allowing the child to develop a clear sense of self or feelings of autonomy (Perosa, 2013). These boundary patterns are common in every family, but in the families of eating disorder adolescents, they have been found in extremes. Families with an adolescent who has anorexia tend to be characterized by enmeshment, conflict avoidance, rigidity, and overprotective parenting. Families with an adolescent who has bulimia are more openly hostile and chaotic, rather than enmeshed (Perosa, 2013). Other common patterns include; high parental expectations, low parental contact, family criticism about weight and physical appearance, parental over-involvement, parental under-involvement, and low affection (Le Grange, 2009). Many families' patterns are negating of the adolescent's emotional needs (Polivy, 2002). These patterns can be found in every family, with or without the presence of an eating disorder. However, when found in extremes, these boundary patterns can lead to the adolescent seeking control or filling their unmet needs through an eating disorder.

While it is important to note that family teachings of body image, communication, emotional expression, and boundaries are not the cause of eating disorders, there is a significant correlation between these factors and the development of eating disorders. These factors, combined with existing biological or psychological stressors, increase the risk of eating disorder development and recovery is compromised. Families, then, can play a key role in the prevention and treatment of eating disorders. Family systems theory helps to identify the role of the family in eating disorder development and work toward a more effective mode of treatment.

This mode of treatment includes the use of family therapy. Family therapy is a form of psychotherapy where issues are resolved in the context of the family unit. During therapy, the family works individually and together to resolve a problem that directly affects one or more members, recognized as the “identified patient” (Brown, 1999). Members work together to understand the group dynamics and how their actions affect each other and the family as a whole. Together, the family works to help the individual in distress and to help relieve the strain on the family. Common themes found in family therapy sessions are family roles, communication styles, autonomy and separation, and family and individual values (Woodside, 1991). Family members explore their individual roles within the family, learn how to switch roles, if necessary, and learn ways to support and help each other with the goal of restoring family relationships and rebuilding a healthy family system (Brown, 1999).

Over the past 25 years, family-based therapy has become a primary form of treatment for adolescent eating disorder patients (Parks, Innovations). However, this was not always the case. Family involvement in eating disorder treatment was introduced in the late 19th century, though psychiatrists Gull and Lasegue asserted that it was essential to limit parent-child contact during treatment to prevent enabling of the illness by the parental support of behaviors (Le Grange, 2009; Woodside, 1991). Interest in family support disappeared for several decades, reemerging as the psychoanalytic movement spread in the middle of the 20th century. In the 1960’s, the role of the family was reframed into a model known as the “psychosomatic family,” where the emphasis was placed on the early interactive familial process. This model advocated for a new form of family therapy as a way to prevent eating disorders in young patients by completely altering the family structure (Le Grange, 2009). Although psychoanalytic theories of family involvement are no longer accepted, discoveries during this time helped to provide new insights

into the internal state of the eating disorder patient, as well as spark new research into the family influence (Woodside, 1991). At the end of the 20th century, as eating disorders were beginning to be understood as complex illnesses with underlying psychological factors, as well as familial and social influences, a paradigm shift began. Beginning with research from London in the 1970s, this paradigm shift directed focus away from the family as the cause, and saw the family as a potential resource for therapy, helping to ease parental blame and guilt (Le Grange, 2009).

Research has shown that family therapy is the most effective form of treatment for adolescents with anorexia nervosa (Costin, 2007). A central belief in eating disorder family-based therapy is that adolescents are unable to make decisions towards their recovery due to uncertainty, ego-syntonic behavior, or resistance to treatment, all common in eating disorders. Parents are given the responsibility of participating highly in or leading, their child's recovery (Murray, 2017). Family therapists can assist the families in expressing feelings, dealing with conflicts, and exploring attachment relationships (Dallos, 2004). Current family models now focus more on facilitation of emotional communication and emotional literacy and assisting family members in developing skills to negotiate conflicts better, recognizing that some rigidity of behavior and emotionality are at times associated with eating disorders (Le Grange, 2009).

Dance/movement therapy is founded on the idea that movement characteristics of an individual reveal how they relate to others and their environment (Padrao, 2011). By exploring a more diversified movement vocabulary, individuals can learn to become more securely balanced, as well as more adaptable to their changing environment (Padrao, 2011). Utilizing the connection between body and mind, changes in movement patterns can result in changes in perceptions of self, and vice versa. In this way, dance/movement therapy addresses some of the core challenges

of individuals with eating disorders; emotional expression and tolerance, communication, control of self and environment, and self-image.

As eating disorders are body-based, dance/movement therapy is uniquely suited to treat symptoms by using the body as the tool, and the movement as the process used to effect integration, growth, and recovery (Padrao, 2011). The American Dance Therapy Association defines dance/movement therapy as “the psychotherapeutic use of movement to promote the emotional, social, cognitive, and physical integration of the individual” (ADTA, 2016). Working under the assumption that individuals with eating disorders are disconnected from their bodies and that eating disorders can represent a patient’s disconnection with their emotional life, dance/movement therapists work to reunify the “broken walls of body, mind, and spirit” (Krantz, 1999, p. 84). Within these broken walls is a “burial site” within the body in which feelings have been buried, and replaced by eating disorder behaviors (Kleinman, 2009, p. 129). Dance/movement therapy provides a means for individuals to move their feelings to the surface, express these feeling through their body, and to communicate how their coping patterns have replaced these emotions. Through this work, individuals can experience a stronger and safer connection with their bodies, learn to trust and tolerate their feelings, and discover the connection with how they move through their environment based on their internal challenges.

Most examples of dance/movement therapy with eating disorders have been to treat clients individually or in group therapy. However, the existing research argues for its use in family therapy based on the goal of integration. It is important to think of an individual as a part of a unit, the family being the first. To integrate the whole person, the therapist must view the person as part of a family system (Dulicai, 2009). While family therapists can attend to the verbal communication of taught patterns, dance/movement therapists are specially trained in the

access and acknowledgment of the non-verbal teaching from parent to child (Falk, 1993). With the non-verbal access, new options of communication and structure become available. This is especially important with the occurrence of alexithymia in both adolescents and parents. The relationships of family members are displayed in the interactional movement behavior. Based on the theories of dance/movement therapy, when changes in these movement patterns occur, so too can changes in the communication and emotional boundaries between family members (Dulicai, 2009).

Discussion

A principal belief in dance/movement therapy is that personality is reflected in movement and that this movement is communicative of wants and needs (Amighi, 1999). By observing the movement patterns of a group of individuals, a dance/movement therapist can attend to how the unique patterns match or clash, how wants and needs are communicated to create harmonious or disruptive relationships (Amighi, 1999). For the families of adolescents in eating disorder treatment, the interpretation and awareness of these patterns can lead to clearer communication between members and regulated boundaries. As dance/movement therapy is body-based and begins non-verbally, it is uniquely suited to assist families with communication and boundaries.

Communication is especially relevant in the treatment of eating disorders, as eating disorders are often indirect and unhealthy modes of communicating unmet needs. As communication is learned within the context of the family, it is important that skills of healthy communication are taught and utilized within family life. There are several ways

dance/movement therapy can assist the family in establishing healthier ways of communication, beginning with non-verbal methods. The practice of attunement could be especially beneficial to families with an adolescent in eating disorder treatment, both as prevention and as a tool to heal. As the adolescent is in a period of life that is difficult to manage, the parent can help by recognizing and attuning to the needs of the child to best support them. The child can also learn how to attune to and appropriately and safely respond to the needs and expression of their family members, without resorting to disordered eating. Also, as alexithymia and difficulties with emotional reflection have been found to exist within these families, attunement is a non-verbal and embodied means of communication and support. To support the treatment goal of healthy communication, families can identify, attune, and adjust to the unique movement patterns of their family members regarding tension flow rhythms, tension flow attributes, and shape flow; components of the Kestenberg Movement Profile (Amighi, 1999).

Communication between individuals begins non-verbally, beginning in infancy. Feelings of safety and support are shared from caregiver to child through attunement. A development of attachment theory, attunement is described by theorist Daniel Stern as “the performance of behaviors that express the quality of feeling of a shared affect state without imitating the exact behavior expression of the inner state” (Treefoot, 2008, p. 16). In other words, attunement is the matching of a particular movement quality of another person’s movement, rather than the exact depiction of the shape or form (Treefoot, 2008). Thought to be foundational to the formation of secure attachment relationships between child and caregiver, attunement is the “dance-like interaction” during non-verbal development stages (Boadella, 2005, p. 13), where the mother can recognize the child’s needs and respond in ways that are emotionally appropriate (Lauffenberger, 2003). To practice attunement, the parent needs to recognize, mirror, amplify, and support the

expressions of the child (Boadella, 2005). For example, a baby will cry, and the mother may respond vocally or bounce the child, matching the rhythm of the cries. When the mother is attuned to the rhythms of the child, the child feels understood and has a sense of stability in the present moment (Siegel, 2007). Attunement allows the caregiver to help the child with distressing situations that may be beyond the child's capacity to manage (Treefoot, 2008).

Through a dance/movement therapy perspective, attunement is the adapting of rhythms to another person's by responsively duplicating changes in muscle tension (Amighi, 1999). Attuning to another's rhythms is based on mutual empathy, which creates shared experiences and communication. An added aspect of attunement is adjustment. This is the process of duplicating movement patterns based on the overall shape of the body. Adjustment to another's shape is based on mutual trust. Adjustment symbolizes the physical support of the caregiver and creates a predictable relationship in which the individual can engage more comfortably in the relationship (Amighi, 1999). Attunement was first studied between mother and infant during the initial periods of development and has been translated by dance/movement therapists into the therapeutic relationship between therapist and client. Using attunement, the dance/movement therapist (known as the attuner) responds to the client's (the mover's) emotional feelings and physical needs. The response can be visual, tactile, or verbal. Visual attunement is exhibited by the attuner observing a rhythm or intensity in the mover's body and duplicating the movement in their own body, though not necessarily in the same body area. Touch attunement is similar but adds the component of physical connection. The attuner might place their hand on the mover and match the tension and rhythm of the movement. Verbal attunement is exhibited through vocal matching, such as the mother matching the vocal volume or intensity of her crying child. The tension is matched initially, but can then be gradually developed into less intense and more

soothing patterns to calm the child. This attunement helps the child feel heard and understood, creating the relationship of trust (Amighi, 1999).

In family dance/movement therapy sessions, the process of attunement can begin with the identification of components of the Kestenberg Movement Profile. Based on developmental theories, the Kestenberg Movement Profile (KMP) expands upon Laban Movement Analysis to reflect how movement patterns evolve through a developmental perspective (Amighi, 1999). Developed from long-term observations of children and their caretakers, the KMP is used as a framework for the treatment and prevention of physical, psychological, and cognitive issues in which movement development parallels psychological development. Under this framework, movement qualities reflect individuals' expression of emotions and needs, defense styles, ways of relating to and coping with others and the environment. More specifically, tension flow rhythms reflect unconscious needs and tension flow attributes reflect temperament (Amighi, 1999).

The first movement category of the Kestenberg Movement Profile is tension flow rhythms. Tension flow rhythms are changes in muscle tension that create specific patterns. Originating from specific biological zones, tension flow rhythms are associated with specific biological functions, which reflect principal needs. Rhythms are categorized by indulging qualities or fighting qualities. Indulging rhythms are self-soothing and reflect a connection to others and ingestion of sensations (Amighi, 1999). Through indulging rhythms, attunement develops between two individuals, starting with infant and mother through breast-feeding, rocking, or swaying. Needs and feelings are shared between two individuals on a physical level through attunement in tension flow rhythms. To increase authentic communication within the family, the dance/movement therapist can assist members in recognizing tension flow rhythms

and attuning to others' rhythms. This can be done in many ways, beginning with the first movement of life, breath. Shared breathing patterns reinforce a sense of connection with others (Amighi, 1999). Through breath, family members can first attend to their bodies and then attune to the breath of others. Another way of practicing attunement is through visual mirroring; one individual watches another individual and duplicates their rhythms, through muscles tension, not necessarily body shape. In doing so, the attuner responds to their family member through physical sensation, creating an opportunity for emotional empathy and support (Amighi, 1999). Through practice, individuals can begin to adjust to the rhythms of their family members more easily. As tension flow rhythms represent needs, members recognize and respond to the needs of others through a different mode of communication.

Just as tension flow rhythms represent needs, tensions flow attributes represent how those needs are met. Tension flow attributes reflect the core temperament of an individual, having the longest persistence from infancy to adulthood of all the movement qualities (Amighi, 1999). Developing during a primarily self-oriented stage, tension flow attributes reflect "subjective evaluations of the environment" (pg. 60). As temperament affects the way in which individuals communicate emotions and handle conflicts in their environment, recognizing and attuning to tension flow attributes is especially important in regards to eating disorders and the family dynamic. The combination of rhythms and attributes is highly individual. It is important to understand that individuals' have their own movement makeup, and family members can learn how to navigate this makeup through attunement. Each individual utilizes the rhythms and attributes differently, as a matter of preference. These preferences are especially relevant in the context of family life, as harmonious or clashing attribute patterns can create positive or negative interactions between people.

Attunement and adjustment can be further practiced through shape flow. Shape flow gives structure to tension flow regarding space. It is categorized by the physical body shape of an individual in which “the rhythm consists of alterations between growing and shrinking” in horizontal, vertical, and sagittal dimensions (Amighi, pg 111). Shape flow assists in the non-verbal communication of an individual’s feelings towards their environment. In shape flow, growing creates open shapes, which reflect feelings of comfort, while shrinking shapes reflect feelings of discomfort. The patterns of shape flow provide the means in which to organize and express internal feelings about external relationships (Amighi, 1999). Body boundaries are enlarged in growing shapes, as the individual feels safe in their environment. However, when an adolescent is growing in an environment that feels uncomfortable or unsafe, there is a mismatch of internal and external.

Growing while in a fear-provoking environment may produce a clash between internal feelings (fear) and their outward expression (growing movement). When there is a disturbance in the balance between feeling and expression, individuals may move in conflicting movement patterns and have difficulty communicating their needs and feelings effectively in relationships. (Amighi, 1999, pg 225)

To create an environment of trust in which needs and feelings can be consistently communicated between adolescents and their family, an aspect of attunement can be utilized. As attunement addresses changes in muscle tension, the addition of adjustment in body shape is important. Adjustment to the shape flow patterns of another individual can create feelings of comfort and safety, as well as flexible boundaries. In this environment of attunement and adjustment, the adolescent can feel more comfortable in expanding their body shape and expressing their needs.

Mutual shape flow is important in the formation of inter-personal relationships, especially between child and caregiver (Amighi, 1999). Beginning in infancy, a child learns a sense of comfort only as their caregiver is comfortable. Through mutual shape flow, the two individuals actively participate in the emotional relationship with each other and their shared environment. This attunement and adjustment begin with breath. When two individuals share a breathing pattern, they physically grow closer together. With the help of the dance/movement therapist, moving from breath to kinesthetic mirroring can help the adolescent and family members understand the non-verbal communication of others.

Dance/movement therapy can also assist in the formation of healthy family boundaries. Boundaries are physical and emotional barriers that exist to distinguish self from non-self, and inner reality from outer reality (Schwartz, 2007). Extreme boundary patterns are common in the families of adolescent eating disorder patients, including enmeshment and rigidity. These patterns can lead the adolescent to seek control or fulfill unmet needs, among other reasons. The meaning of healthy boundaries can then mean flexible boundaries, rather than remaining in extremes. The dance/movement therapist can help the family in establishing flexible boundaries, beginning with clashing and fighting rhythms and exploration of the kinesphere.

While attunement is important in forming relationships and healthy communication, too much attunement can create a blending of individuals, making separation difficult. This separation is important in adolescence, as new patterns and ways of coping are necessary for development and in preparation for adulthood. An adolescent may feel inept without their caregiver and unable to mature, may be particularly sensitive to the rhythms of their caregivers and adjust too often, or may feel stifled by rigid boundaries. In these cases, an eating disorder can develop to act as the unhealthy tool of separation and means of control. It is then important

to replace disordered eating behaviors with healthier patterns that support differentiation. In families with extreme enmeshment and adolescents with a limited sense of self, clashing patterns and fighting rhythms can be utilized in treatment.

Through fighting rhythms, specifically snapping/biting, the periphery of the body is defined, creating distinct body boundaries and differentiation (Amighi, 1999). To discover these physical boundaries, the dance/movement therapist can lead the family in patting their bodies using the biting rhythm. Individuals can experience themselves as whole, separate beings. By patting the surrounding area, such as the ground, individuals can experience a sense of otherness. For families with enmeshment or unclear boundaries, differentiation through physical touch can lead to differentiation of needs and feelings. While access to indulging rhythms demonstrates an individual's capacity to be vulnerable, fighting rhythms demonstrate an individual's ability to protect themselves, both of which are important for navigating difficult situations, such as adolescence or parenting an adolescent (Amighi, 1999). Each family's needs will be different, but exploring the differences between indulging and fighting rhythms can lead to greater flexibility and adaptation, first physically, then emotionally. This adaptation can help families and the adolescent to prevent or navigate the under or over-controlled environments in which eating disorders develop.

By observing tension flow attributes, the dance/movement therapist and family can understand how individuals' boundaries are exhibited and affect the family as a whole. Tension flow describes the observable flow of muscle tension, ranging from bound to free, with various levels of intensity (Amighi, 1999). In the course of movement, an individual's muscles contract and release in patterns based on the present task, individual temperament, and the individual's comfort in the environment. The tension flow attributes of free flow, bound flow, and neutral

flow can act as protective mechanisms in several ways, affecting personal boundaries. Free flow is utilized when an individual wishes to escape an unpleasant situation and throws oneself towards safety. Movements flow without restraint or control, sometimes leading to a loss of boundaries with others. On the opposite end, bound flow is characterized by immobilization or freezing in response to unpleasant situations. While bound flow is helpful in defense, too much can create inflexible relationship boundaries. Similarly, neutral flow numbs unpleasant thoughts and feelings as a protective mechanism. However, this also numbs an individual from adapting to their environment and forming meaningful relationships (Amighi, 1999).

As free flow, bound flow, neutral flow, and other tensions flow rhythms affect the boundaries between people and how they adapt to unpleasant situations, they are especially relevant to the experiences of eating disorder patients and their family members. By identifying the tension flow attributes used by the members and discussing how these rhythms are related to protective mechanisms and boundaries within the family, the dance/movement therapist can assist in using these individual preferences as strengths. The family can attune to the tension flow attributes by utilizing mirroring or trying on the various attributes in their bodies. This attunement can then translate to situations in their family life when conflict arises or through periods of change. With the bodily understanding of their family members and exploration of changes in tension flow, the flexibility of boundaries is possible (Amighi, 1999).

Boundaries include an important element of space. Internal boundaries can be exhibited by external boundaries, meaning the amount of space between an individual and others. With families who have enmeshed boundaries, the physical boundaries between the individuals might be thin, shown by physical touch or close proximity. Families with extremely rigid boundaries may exhibit large amounts of space between each other or limited exploration of the space they

share. In Laban Movement Analysis, the kinesphere describes the space used around the body, whether still or in motion (White, 2009). It can be imagined as an imaginary bubble surrounding the body, traveling wherever the body moves. Movers can be in the body in near space (closest to the body), middle space, or far reach (edge of the kinesphere) (White, 2009). In sessions with the family, the dance movement therapist can observe individuals' use of the kinespheres and how members interact with the kinesphere of others. The therapist might ask what the adolescent feels when a family member enters their kinesphere or how family members maintain their kinespheres, alternating between the imagery of a fragile bubble and a solid brick wall. Flexible boundaries can be created by exploring personal kinespheres, observing the relationship of multiple kinespheres, and discussing the relationship between internal boundaries to these observable external boundaries. Through the use of elements of the Kestenberg Movement Profile and Laban Movement Analysis, the dance/movement therapist can assist the family in establishing healthy communication and flexible boundaries. These elements benefit the family by dealing with a body-based disorder using a body-based and primarily non-verbal form of treatment.

As the family plays a key role in the adolescent's development and a correlation exists between family behaviors and eating disorders, family dance/ movement therapy would greatly benefit the adolescent and family as treatment and prevention. Dance/movement therapy provides a non-verbal and body-based method to observe, assess, and explore the relations between family members dealing with a body-based illness. Boundaries and communication are the focus of this paper, and all families will have individual needs related to these topics. With flexibility and curiosity, the dance/movement therapist can work with each family in a way that best suits the environment, culture, and makeup of the family. Further movement observation

and analysis is needed of families in relation to members diagnosed with an eating disorder. With this research, dance/movement therapy can become a primary treatment for the millions of families healing from eating disorders.

References

- American Dance Therapy Association (2016). What is dance/movement therapy. Retrieved from adta.org.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.
- Amighi, J., Loman, S., Lewis, P., & Sossin, K.M. (1999). The meaning of movement: Developmental and clinical perspectives of the Kestenberg movement profile. Routledge: New York.
- Boadella, D. (2005). Affect, attachment, and attunement: Thoughts inspired in dialogue with the three-volume work of Allan Shore. *Energy and Character: The Journal of Bioenergetic Research*, 34, 13-23.
- Brown, J. (1999). Bowen family systems theory and practice: Illustration and critique. *Australian and New Zealand Journal of Family Therapy*, 20 (2), 94-103.
- Cooper, S., & Norton, P. (2008). *Conquering eating disorders: How family communication heals*. Berkley, CA: Seal Press.
- Costin, C. (2007). *100 questions and answers about eating disorders*. Sudbury, MA: Jones and Bartlett.
- Dallos, R. (2004). Attachment narrative therapy: Integrating ideas from narrative and attachment therapy in systemic family therapy with eating disorders. *Journal of Family Therapy*, 26, 40-65.
- Dulicai, D. (2009). Family dance/movement therapy: A systems model. In S. Chaiklin & H. Wengrower (Eds.), *The art and science of dance/movement therapy: Life is dance* (pp. 145-158). New York, NY. and Hove E. Sussex: Routledge.

- Eating Disorders Victoria (2017). Eating disorders and adolescents. Retrieved from eatingdisorders.org
- Engel, B., Reiss, N.S., & Dombeck, M. (2007). Eating disorders: Historical understandings. Retrieved from mentalhelp.net.
- Falk, M. G. (1993). Family therapy and dance/movement therapy: An integration. (Unpublished doctoral dissertation). Goucher College: Towson, Maryland.
- Haworth-Hoepfner, S. (2000). The critical shapes of body image: The role of culture and family in the production of eating disorders. *Journal of Marriage and Family*, 62 (1), 212-227.
- Kerr, Michael E. (2000). One family's story: A primer on Bowen theory. The Bowen Center for the Study of the Family. <http://www.thebowncenter.org>.
- Kleinman, S. (2009). Becoming whole again: Dance/movement therapy for those who suffer from eating disorders. In S. Chaiklin & H. Wengrower (Eds.), *The art and science of dance/movement therapy: Life is dance* (pp. 125-144). New York, NY. and Hove E. Sussex: Routledge.
- Kleinman, S. (2016). The body speaks: Dance/movement therapy creates movement toward eating disorders recovery. *Gurze-Salacore Eating Disorders Resource Catalog*.
- Krantz, A. (1999). Growing into her body: Dance/movement therapy for women with eating disorders. *American Journal of Dance Therapy*, 21 (2), 81-103.
- Lauffenburger, S. (2003). Attunement. *Dance Therapy of Australia Association Journal*, 2 (3), 12-18.
- Le Grange, D., Lock, J., Loeb, K., & Nicholis, D. (2009). Academy for eating disorders position paper: The role of family in eating disorders. *International Journal of Eating Disorders*, 1-5.

Murray, S., Anderson, L., Rockwell, R., Griffiths, S., Le Grange, D., & Kaye, W. (2017).

Adapting family-based treatment for adolescent anorexia nervosa across higher levels of patient care. In Murray, S., Anderson, L., & Cohn, L. (Eds.), *Innovations in family therapy for eating disorders: Novel treatment developments, Patient Insights, and the Role of Carers* (pp. 3-14). New York, NY: Routledge.

National Eating Disorders Association (2018). Health consequences. Retrieved from nationaleatingdisorders.org.

Padrao, M.J. & Coimbra, J.L. (2011). The anorectic dance: Towards a new understanding of inner-experience through psychotherapeutic movement. *American Journal of Dance Therapy*, 33, 131-147.

Parks, E., Anderson, L., & Cusack, A. (2017). Adolescent impressions of family involvement in the treatment of eating disorders. In Murray, S., Anderson, L., & Cohn, L. (Eds.), *Innovations in family therapy for eating disorders: Novel treatment developments, Patient Insights, and the Role of Carers* (pp. 208-219). New York, NY: Routledge.

Perosa, L., Perosa, S., & Einsporn, R. (2013). Individuation/attachment relationships mediating between overall family boundaries and drive for thinness and bulimia behaviors reported by college females. *American Counseling Association*, Article 40.

Polivy, P., & Herman, P. C. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.

Schwartz, A. (2007). Eating disorders and family boundaries. Retrieved from mentalhelp.net.

Siegel, D. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. WW Norton: New York.

Treefoot, A. (2008). *Moving together: Enhancing early attachment using dance movement therapy*. (Unpublished masters thesis). Whitecliffe College of Arts and Design:

Auckland, New Zealand.

White, E. Q. (2009). *Laban's Movement Theories: A dance/movement therapist's perspective*. In S. Chaiklin & H. Wengrower (Eds.), *The art and science of dance/movement therapy: Life is dance* (pp. 217-235). New York, NY. and Hove E. Sussex: Routledge.

Woodside, B., & Shekter-Wolfson, L. (1991). *Family approaches in treatment of eating disorders*. American Psychiatric Press: Washington, D.C.