Review Article

Returning to the own body: Dance Movement Therapy and Eating Disorders

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Abstract

Eating disorders produce the highest mortality rate in the field of mental disorders. Their prevalence has increased remarkably in recent decades. Its multicausal origin and changes in diagnostic criteria increase its complexity. There is still a long way to go, on the one hand in preventing them, but also in the search for effective treatments that guarantee adherence to treatment and avoid relapses.

This article shows an overview of eating disorders and presents Dance Movement Therapy (DMT), one of the creative therapies, as a psychotherapeutic app-roach of great interest when working with persons suffering from eating disorders.

DMT uses creative movement, analysis of movement patterns, symbolism, metaphor, and kinaesthetic empathy in a therapeutic context. Its differentiating characteristics and evidence-based research on its efficacy in the clinical setting are presented. The areas of intervention and the general objectives to work with this population are also offered, without intending to be exhaustive. To end

with, a couple of brief vignettes illustrating the work made using this approach are presented.

***Keywords**: eating disorders, dance movement therapy, creative therapies, intervention, vignettes*

1. What is Dance Movement Therapy?

1.1. Origins and Characteristics

Dance Movement Therapy (DMT)[1] belongs to the group of so-called creative therapies and shares with them some characteristics under a non-directive work environment: creative process, self-expression, active participation and body-mind connection (Malchiodi, 2005). It is not a question of "what to do" with patients but of "being with" patients by using experience to guide and orient treatment (Hornyak & Baker, 1989a). DMT is formally defined by the American Dance Movement Therapy Association as "the psychotherapeutic use of movement as a process that promotes the emotional, cognitive, physical and social integration of the individual".

To understand the essence of DMT, it is necessary to go back to its origins and development. Since ancient times dance has been intimately connected to the history of human beings, enabling the integration of the individual into society through rituals, enabling social relations and healing processes. Dance and movement represents mechanisms of communication prior to language. This is equally true at the individual level where the baby begins to become aware of its own existence, of its self from a preverbal, transmodal place of communication with its main caregiver (Beebe et al., 2003; Stern et al., 1985). At the beginning of the 20th century, innovative and groundbreaking ideas emerged in various fields.

In the field of dance, greater importance and space began to be given to free expression and creative movement, moving away from the technical demands and aesthetic canons that prevailed in classical dance. Thus, a group of dancers and choreographers began to become aware of the importance of movement and dance as a therapeutic and self-awareness resource. In the 1930s and 1940s, the pioneers of Dance Movement Therapy began to emerge in the United States. Its greatest exponent was Marian Chace. Her achievements in working with schizophrenic patients in hospitals made it possible to begin to recognise dance

1 Some countries use the term Dance/Movement Therapy or Dance Movement Psychotherapy, depending of national regulations on psychotherapy.*

as a means of therapeutic treatment to address emotional problems, especially in patients with difficulties in verbal expression. Other notable work emerged, such as that created by María Fux in Argentina. Subsequently, other dancers interested in creative and expressive dance followed suit. Once again, priority was given to the individual expression of the person, his/her emotions, his/her desires and needs as a starting point for creativity. At the same time, the studies on movement that had begun a century earlier with Darwin's early research on facial and bodily expressions in psychiatric patients (Darwin, 1872) spread out with Laban and Lamb being the greatest exponents. Similarly, the birth of psychoanalysis sparked a great interest in the mind and the unconscious, which was then transferred to the body and body language. The psychiatric theories of Freud, Jung, Winnicott, Adler, etc. on the relationship between the psyche, the body and the emotions were disseminated. All these advances nurtured what today is the body of knowledge on which DMT is based (Chaiklin & Wengrower, 2008; Payne, 2003).

1.2. Specific Characteristics of DMT

Nowadays, discipline combines and synthesises the study of social, psychological and developmental processes together with kinesiological and biological principles and methods of movement analysis. The fundamental principles of DMT are the concept of embodiment, body awareness, the meaning of symbolic movement and the creative process in the context of therapeutic alliance. The term embodiment (Koch & Fuchs, 2011) has been widely studied in the last decades since neuroscience (Damasio, 1999) revealed that cognitive structures are formed from a physical body and that there is a continuous relationship of communication and learning between different body structures (including mental structures) and biological mechanisms. DMT works with the relationship between movement and emotional response, knowing that changes in the form and qualities of movement also produce changes at the physiological level (Jeong et al., 2005; S. Koch et al., 2014). In this sense, it is worth highlighting the contribution to DMT of movement analysis and observation tools such as Laban Bartenieff Movement Analysis (Hackney, 2003; Laban & Ullmann, 1971) or Kestenberg Movement Profile (Amighi et al., 2018). These tools are used both as diagnostic tools and in treatment processes, allowing the exploration of different movement patterns, fixations and deficiencies, needs and resistances, the access to unconscious material, and offering new ways of relating through creative exploration of different qualities of movement in the therapeutic space.

In addition, the particularity of working with the symbolic meaning of the nonverbal expression in a transitional spa-

ce (Winnicott, 1971) generates the development of the creative and indistinct expression of each individual (Koch et al., 2019). In fact, as in other creative therapies, the creative process is a distinctive aspect of the practice. The goal is not the production of an artistic work, so it is not necessary to have the prior artistic ability in order to participate in a DMT session. As an artistic activity, dance is a way of expressing desires and even realizing them, both from a symbolic point of view. It is through the representation of the symbolic that the person can reach his or her unconscious. The metaphors that emerge in movement are revealing patient's inner state and are the generators of change and transformation (Meekums, 2002; Wengrower, 2008). Winnicott (1971) has had a special influence on the profession with his concepts of transitional phenomena, play and creativity. For this author, the creative process is a foundational aspect of the development of the individual and their relationships; these developmental phases and the way of relating to the environment are relived in a therapeutic session.

For Winnicott, psychotherapy is a terrain in which the playgrounds of the patient and the therapist overlap. The concept of play thus takes on a special meaning, although it is always a creative experience. Play also implies trust, and belongs to the potential space between (what was at first) the baby and the mother figure. The work with symbols and metaphors is enriched by finding words for what has emerged in a movement when it is possible to verbally close the session (which is not possible for all patients).

Therefore, spontaneous movement as part of the creative process enables unconscious content to emerge. But this is not enough. This needs to take place in a relational context, in a therapeutic setting, a container in which the therapist accompanies the client/patient in exploration and awareness. Transference and countertransference are a substantial part of the process, and kinaesthetic empathy enables the dance movement therapist to tune in and resonate with the emotional content of the client through the empathic reflex giving the client/patient the experience of being seen, recognized, and accepted (Koch et al., 2011; Rizzolatti et al., 2001).

The concept of kinaesthetic empathy is very important in DMT. The possibility of empathically connecting with the patient through posture and movement qualities has been a tool used for decades, together with intuition and active listening of dance therapists (Koch et al., 2011). In recent decades, this intuitive knowledge has been ratified by research in the field of neuroscience and cognitive psychology. The discovery of mirror neurons, first in primates and then in humans, and of the whole specular system, has generated a great deal of research on how our brain is activated by observing the movement

of the other (as if we were moving ourselves) (Rizzolatti & Siniglia, 2008). Further research has also shown the relationship between the specular system and smell and sounds. The specular system allows us to understand in part the basis of our ability to imitate, to empathize with others, to anticipate behaviors and actions, and to communicate with others as the social beings that we are (Rizzolatti et al., 2001). Functional magnetic resonance imaging has shown how the specular system in the brain of a person with autism, for example, shows differences with that of a person who does not have it, which seems to provide information about the difficulties that individuals with autism have in empathizing and anticipating the intentions of others (Williams et al., 2001). Studies on embodied cognition contribute to the recognition of the importance of motor action in the formation of cognition, and thus provide justification for the use of dance and movement in the therapeutic context (Berrol, 2006).

1.3. Current State of the Profession in Europe

The elements briefly mentioned in the previous section differentiate Dance Movement Therapy from other psycho-corporal approaches. And research, growing in recent decades, provides evidence of its effectiveness with different populations and contexts as dementia, depression, eating disorders, and older adults (Bräuninger, 2012; Karkou et al., 2019; Koch et al., 2019; Lyons et al., 2018; Meekums et al., 2015; Savidaki et al., 2020). Traditionally, the field of application of DMT has been clinical, although there is a growing interest in the field of health promotion and prevention (Martin et al., 2018; Rodríguez-Jiménez et al., 2022; Rodríguez-Jiménez & Carmona, 2021), which is also recognised by the WMO (Smyth et al., 2020). More and more, DMT is being used in social, educational and/or professional environments for the development of interpersonal competencies and health promotion (Rodríguez-Jiménez & Carmona, 2020).

The different Dance Movement Therapy associations worldwide contribute to the visibility and knowledge of this psychotherapeutic approach. In Europe, the EADMT brings together 29 national associations and works for the recognition of the profession, the existence of training standards that enable the movement of professionals in Europe, and promotes research in the field. Dance movement therapists have specific postgraduate training that includes fundamentals of psychology and psychotherapy, motor development, creative movement, methods of observation and movement analysis, psychopathology, clinical practice, supervision and research. Nowadays, dance movement therapists work in different types of institutions and therapeutic settings. In psychiatric institutions, in hospitals (eating disorders, chronic illnesses such as cancer, brain injuries, blindness,

etc.), educational institutions (special education, developmental delay, autistic spectrum), centres dedicated to helping people with drug addiction problems, survivors of various forms of violence, elderly, etc.

2. Dance Movement Therapy and Eating Disorders

2.1. Eating Disorders

Eating disorders (ED) are considered as one of the most complex illnesses in the world (Galmiche et al., 2019; Zerbe, 2007). People with eating disorders have unhealthy attitudes related to food and its intake. They also show excessive and reiterative thoughts about weight or shape or body image looking for mechanisms to control their intake of food. According to the DSM-V, there are different types of eating disorders with marked differences in symptomatology and diagnostic criteria, the most prevalent being anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder. The syndromes have a significant influence on the quality of life and social function, and some individuals may develop severe complications that can cause a higher risk of suicide and mortality rates, especially in anorexia nervosa (AN) (Preti et al., 2011; Rosling et al., 2011).

In fact, eating disorders have the highest mortality rate of all mental illnesses (Smink et al., 2012). They are considered mental health illnesses because there is psychological distress, fear of gaining weight, and distorted body image. Body image disturbance has consequences on cognitive, emotional and behavioural levels (Cash & Deagle, 1997). People with ED also show higher levels of alexithymia, a personality trait characterized by an inability to identify, recognize and modulate one's feelings and body sensations. Alexithymia is also associated with difficulties in creativity, symbolization and play (Nowakowski et al., 2013). Comorbidity is also common in ED, with depression, anxiety, substance abuse, and social phobia that run in parallel with the ED (Allen & Dalton, 2011). The reported prevalence of eating disorders varied widely ranging from 0,1 % to 3,8% (Duncan et al., 2017), due both to methodological differences in epidemiological studies and to successive changes in diagnostic criteria, which makes it difficult to obtain reliable and confirmed data, although a higher prevalence has been demonstrated in Western countries (Qian et al., 2022).

Still, studies show a clear and alarming increase in the prevalence of ED over a given period, from 3.5% in 2000-2006 period to 7.8% in 2013-2018 period (Galmiche et al., 2019). Corona virus disease (COVID-19) has also had important consequences in terms of the mental health of the population with significant increases in posttraumatic

stress, anxiety, and depression (Hossain et al., 2020). Until now, the effect of COVID-19 on ED patients remains unknown, but according to some preliminary studies, the concerns about health and fitness during confinement could serve as a precipitating factor for the development of an ED in individuals with certain vulnerabilities (Fernández-Aranda et al., 2020). In fact, the pandemic has had a great impact on the mental health of children and adolescents, which has been exacerbated in those with vulnerability to the development of an ED.

Different European hospitals described a higher rate of overall admissions regarding ED during the pandemic and after it, related to an increase in exercise, social media time consumption, a perceived feeling of losing of control, and the lack of face-to-face medical assistance (Gilsbach et al., 2022).

The latest research indicates that the risk factors that can lead to ED can be a combination of biological, psychological, and social factors (Dalle Grave, 2011). The social networks that have emerged with the development of technology have contributed to an expansion of models of a certain body image and beauty stereotypes that, especially in adolescence, can contribute to the imitation of behaviours that act as a trigger in combination with a certain susceptibility in some individuals (Cash & Smolak, 2011). Certain personality traits such as neuroticism, perfectionism, and obsessiveness can also predispose to an eating disorder, particularly AN and BN. These characteristics may contribute to difficulty in healthy eating.

The lack of awareness of inner experience and the difficulty of trusting the perception of one's emotions and sensations of patients with ED leads to a sense of low self-efficacy, as they are unable to resolve the conflict between the illusion of perfectionism, their actual capacities, and the expectations of others (Bruch, 1973). According to some studies patients with AN show high levels of harm, avoidance, preoccupation, pessimism, the rigidity of thought, and an absence of seeking new experiences. In BN, a search for novelty appears, which seems to be related to the lack of impulse control and subsequent binge eating and purging behaviours (Fassino et al., 2002). Unhealthy early experiences also appear to be a possible causal factor. In fact, several studies point to the insecure attachment as a clear risk factor (Zachrisson & Skårderud, 2010). Origins for self-regulation and emotional regulation are rooted in the creation of a secure attachment with the caregiver. The way in which an individual understands interpersonal relationships and closeness to others seems to transfer in some way to the relationship with food (Cassidy and Shaver, 1999).

Treatment is one of the challenges in EDs. The most widespread is the cognitive-behavioral approach in its different approaches, both in individual and gro-

up sessions or incorporating the family (Allen & Dalton, 2011; Bucharová et al., 2020). Family therapy (Agras & Robinson, 2008; Jewell et al., 2016) and psychodynamic approach (Castellini et al., 2022; Zerbe, 2001) have been widely used. Pharmacology is also commonly used, especially when there is comorbidity with anxiety or depression. Treatment models which address attachment styles should be encouraged. Szalai (2019) makes a major contribution by reviewing the potential mediators' factors between dysfunctional attachment and eating disorders symptoms together with a big number of investigations showing improvements in patient treatment when intervention is focused on those factors, not just on behavior and automatic thoughts.

According to this author the factors that mediate between attachment dysfunctions and eating disorders are: poor self-concept, sensitive interpersonal style, body dissatisfaction, perfectionism, depression, alexithymia, emotional dysregulation, disorganized mental states, and low reflective functions. Depending on the individual psychopathology, some of them can be relevant paths for a successful therapeutic intervention (Szalai, 2019). Further efforts with interdisciplinary approaches and well-defined therapeutic intervention protocols are needed to draw definitive conclusions about their efficacy.

2.2. Arts-Based Therapies and Eating Disorders

Creative therapies are a specially indicated resource both in the prevention and treatment of ED (Malchiodi, 2005). The so-called creative therapies or arts-based therapies, which include music therapy, art therapy, psychodrama and dance movement therapy, share a non-directive approach that focuses on non-verbal communication within a therapeutic relationship. They use imagery, symbolism and metaphor to reach the emotional states of the patient (Winnicott, 1971). Although the communication channel is a certain artistic modality, the focus is not on the product but on the creative process that occurs during the setting. All of them encourage active participation, self-expression and the mind-body connection.

In the case of the ED, and given that the protagonist is the body itself, Dance Movement Therapy offers a place of recognition and attention to the connection of body and mind and to the non-verbal manifestations. It is from the non-verbal that the attachment style established in early childhood (Beebe et al., 2003; Stern et al., 1985), and it is from the body that one's psyche, modes of emotional regulation, and self-awareness are organized (Damasio, 1999). Non-verbal interactions allow insights regarding patients' behaviours, beliefs, emotional states and relationship patterns. Verbal communication is integrated in DMT by

giving meaning to the symbolic aspects of the movement.

This movement from the nonverbal to the verbal expression occurs in a therapeutic setting in which the relationship between the therapist and the patient is crucial. Non-verbal manifestations are considered pre-symbolic communicative aspects. The therapist observes, accompanies, and suggests proposals that enhance the possibility to inhabit one's own body, to increase self-awareness and emotional regulation. One of the specific tools that a DM therapist uses is kinaesthetic empathy, rooted in the concept of affective attunement that occurs between the mother and the baby at a non-verbal level (Stern et al., 1985).

The therapist reflects through his muscular and verbal activity what he perceives in the movement and the patient's body; this allows the therapist to connect with the patient by sharing the subjective state, the emotional content. This contributes to validating and legitimizing the patient's experience. Neuroscience brings evidence of mirror neurons and neurobiological mechanisms showing the ability to read, empathise, and resonate with another person's state of mind, intentions, experience, and/or movement (Rizzolatti et al., 2001). This promotes an intersubjective consciousness, in which there is an intersubjective experience and a co-creation of a shared journey of feelings between therapist and patient (Berrol, 2006; McGarry & Russo, 2011; Rizzolatti & Sinigaglia, 2008). In this way, felt experience is expressed through the movement qualities offering a great potential for authenticity and transformation.

There is considerable evidence on the contribution of creative therapies in ED, although more effort is required in carrying out research projects with a methodology that can be replicated and contrasted (Cruz, Robin, & Berrol, 2012; Hornyak & Baker, 1989a). Some of the work had a focused on trying to identify characteristic movement patterns in EDs (Hornyak & Baker, 1989a). With all the necessary precautions, since each patient is unique, it is possible to find some recurrent patterns in patients with anorexia nervosa and bulimia: peripheral and stereotyped movements, shallow breathing (with high-pitched voice tones in AN), purging posture, inactive trunk, difficulties in the use of space, lack of sense of time or exaggerated liveliness (in BN), lack of connection and integration of the different parts of the body and lack of modulation in strength.

Regarding the efficacy of DMT-based interventions, different studies have shown significant improvements in decreasing psychological distress and anxiety, acquisition of a more realistic body image, increasing self-esteem, reducing alexithymia, and improvement of the quality of relationships (Meekums et al., 2012; Savidaki et al., 2020; Kleinman & Hall, 2006, 2015, 2016; Krantz, 1999; Franks

& Fraenkel, 1991; Kleinman, 2015, 2018; Krantz, 1999; Meekums et al., 2012; Muller-Pinget et al., 2012; Pylvananien, 2003; Savidaki et al., 2020; Sundgot-Borgen et al., 2020); Pylvananien, 2003).

2.3. Areas for DMT Intervention

According to different authors (Pylvananien, 2003; Rice, 1999; Rodríguez Jiménez et al., 2013; Stark et al., 1989) there are three general areas of action that are worth mentioning:

a) Self-confidence and self-esteem, rebuilding the self: the aim is to increase the degree of self-awareness, self-understanding, and self-acceptance (Gillespie, 1996). All individuals possess a sense of their embodiment, which in essence is a preverbal experience established before any verbal or conceptual pattern has developed. Physical experience is an im-mediate mode of knowing as well as experiencing the self. To people who have strong verbal defenses, move-ment can give a more reliable identification with their feelings than words, allowing them to acquire greater levels of self-confidence. The gain in self-confidence competence also has the effect of lowering resistance to change, and therefore greater adherence to treatment.

b) The body: awareness, integration and body image. The concept of body image is a complex one and has been addressed by numerous authors. In the work of Gracia & Rodríguez-Jiménez (2011) a review of the term is made from different theoretical orientati-ons. In DMT with people with ED, ac-quiring a more realistic body image of one-self is a core objective (Cash & Smolak, 2011; Hornyak & Baker, 1989b; Schwartz & Brownell, 2004). The work is oriented towards achieving a body that is less limited by tensions and conflicts. To this end, work is carried out on the basis of awareness of the body and the existence of body boundaries, as well as the coordination and integration of the different parts of the body into a healthier and more adaptive body schema for the person.

c) Intra- and interpersonal competencies: as already mentioned, people with ED suffer from severe distortion of their body image and have low self-esteem and poor self-concept, which results in difficulties in expressing their feelings and problems in interpersonal relationships. For this reason, for these patients, participation in a movement therapy group is clearly of great value (42). The aim is to establish a basic level of communication through the use of rhythm, space, objects and physical interaction. Group sessions also allow for increased self-awareness through feedback from observing others in movement (43). By witnessing the expression of feelings in the bodies of others, patients begin to identify and recognise their own feelings (44). They also learn that the-

re is a wide range of possibilities in movement patterns, and thus in behaviours and expressions, gradually becoming able to experience new and healthier ways of relating to their own bodies and to others (45).

These areas of action are clearly inter-related, and it is not possible to work on any one of them in isolation from the others. In eating disorders, the body is not only the vehicle through which the disorder or pathology manifests itself, but it is itself the hated or feared object. The areas can be specified in general objectives that must be adjusted to the characteristics and needs of each individual or group.

1. Developing **self-confidence**: using movement qualities, planes, and kinesphere.
2. Developing **body awareness** and a more realistic body image: breathing, skin as boundary, and envelope. Awareness of muscles, bone structure, and organs.
3. Developing a clear **sense of self and bodily boundaries** which is self-differentiation by using objects, bodily sensations, images.
4. Increasing **autonomy and self-esteem**: pull/push movements, polarities in movement qualities.
5. Promoting **interpersonal relationships** avoiding loneliness and isolation: games, create figures in group, change of leadership promoting movements, kinaesthetic empathy.
6. Facilitating the identification, tolerance and expression of **emotions** in a constructive way: by using images and objects, creating stories in movement, kinaesthetic empathy.
7. Increasing **vitality and pleasure**: playing with objects, sensations.

3. Short Vignettes of DMT Sessions

In this section, three vignettes are presented as an example of working with DMT and eating disorders. The first two show processes of adolescent patients admitted to a hospital who participated in a closed group therapy with DMT. The 16 sessions were held in a multipurpose space in the same ward. Each session lasted an hour and a half. The group consisted of 8 adolescents, 6 of whom had a diagnosis of restrictive anorexia, 1 of bulimia, and 1 of binge eating disorder.

The last one shows individual work with a patient with bulimia. In this case the duration of the treatment was 24 weeks, with one weekly individual session. At the end of this period the patient moved to another city, so we had to close the intervention accordingly.

The group sessions allow for working with the group dynamics, which is formed and developed as such throughout the process. In this case, the group was constituted as a closed group to allow a similar de-

velopment for the different members and to avoid, as much as possible, attitudes of imitation of behaviors. The sessions followed a defined structure, and only in the middle of the process was it possible to introduce more free movements and creativity. In the first sessions, this was not possible, as the patients had difficulties moving spontaneously. In addition, except for the patient with bulimia, the rest had difficulty verbalizing at the end of the session. As a therapist, I perceived fatigue, resistance and lack of confidence in relation to the verbal work they were already doing in the hospital therapeutic sessions.

So, during the first sessions, the interventions addressed increasing body awareness, building confidence in the space, the therapist, and the group, strengthening treatment adherence, and identifying and expressing emotions and body sensations. The use of other creative materials such as images, collages, and drawings made it possible to express what was happening during the session, the sensations, thoughts, and emotions that arose. They also served as a lever so that little by little the verbal could appear at the end of the session. During following sessions the previous work was deployed towards the search for resources to increase awareness in relation to motor patterns, explore different ways to move and relate with themselves, and increase connection with others. There were numerous play proposals that gave them the possibility to gain confidence in this space of acceptance and non-judgment to explore aspects of their own self.

Vignette 1

Helen, a skinny, short 14-year-old girl, is in the middle of a DMT group process at the hospital where she was admitted with a diagnosis of restrictive anorexia two months ago. She does not like to be there. During the 6 previous sessions, Helen has remained silent and has participated in some of the activities selectively, always preferring those in which she could perform energetic and fast movements. Her movements are rigid, peripheral and there is no connection with the torso. She has not been able to get involved in activities that had to do with self-contact, neither through the use of objects. In each session, during the transition time towards the end of the session, the patients could choose cardboard and make a drawing or a collage with different materials made available to them. Helen showed an impressive creative capacity, making high quality drawings and using the materials to complete innovative and creative collages by combining images from magazines with her own drawings.

All her drawings were always enclosed with thick and firm strokes, and there are many images that refer to feeling enclosed, isolated. For the first time, in this session, Helen was able to make some non-stereotyped movements, she closed her eyes for a minute and moved her arms in the air indirectly and with a light weight. And then she played with another partner for the first time. After drawing, Helen shares that she always feels trapped in her body, a body that she hates, that she despises. But that today she felt something softening in her body, that during the session today she has enjoyed, also relating to another young woman. She says she realized her difficulties, and nevertheless she thinks that her body can still enjoy.

She chooses some pictures of birds for her collage. I see her smile for the first time. She expresses her desire to keep trying and searching for the sensations of lightness and freedom that she has experienced today. During the next sessions we will continue to explore joy, enjoyment and relationship with others through play with different qualities of movement and sensory imagery.

Figure 1 Collage made by Helen during the session described.

Vignette 2

Sonia is a 15-year-old girl. This is the second time she has been admitted. The first time was when she was diagnosed with bulimia, she was 12 years old. Now she was admitted with diagnosis of anorexia nervosa. She is aware of her illness and wants to be cured. She actively participates during the DMT sessions. She states that they make her feel relaxed and calmer. Her movement profile shows a very light weight, when walking she seems to be floating. However, her torso is tense, her breathing is very shallow and there is a great heaviness in her arms and shoulders.

During the fifth session she mentioned feeling insignificant, unimportant to others. In the seventh session, she performs strong movements with her arms and hands, hitting a cushion.

I encourage her to try to carry this movement to the rest of her body. She gradually begins to tap her feet on the floor in a rhythmic way. The whole group follows her. More and more forcefully. Then she leaves the cushion and begins to walk rhythmically around the space with weight on her legs. The group accompanies and follows her. It doesn't last long, she soon shows fatigue. When she stops, I notice that her breathing is a little deeper and I encourage her to connect with it. I can feel the group breathing. At the end of the session, she says with surprise that the group has seen her strength and have accompanied her journey following in her footsteps without judgement. She says: "I am here, I am, you can see me".

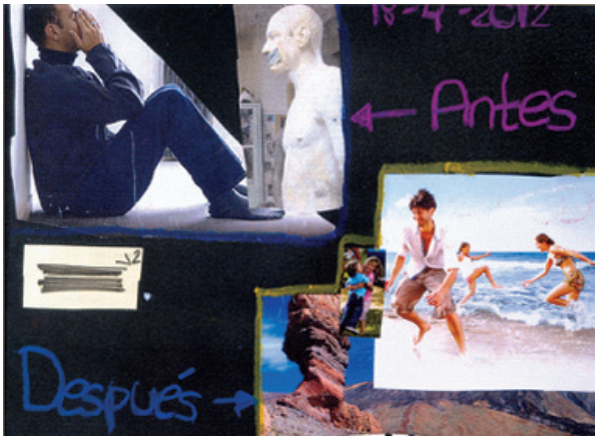

Figure 2 Collage made by Sonia during one of the sessions.

Touched by these words, I give her back a "Yes, you are here, I see you, we all see you". Tears roll down her face. This aspect of feeling recognized, legitimized, understood and accompanied by the group is something that all patients perceive as an important and healing aspect of the sessions. This can also increase self-confidence, self-awareness, and avoid isolation. They are grateful for that.

Vignette 3

Susan is a 26-year-old woman who comes because she has had a recurrence of binge eating episodes. She recounts dysfunctional eating problems since adolescence and emphasizes her relationship with her parents. She lives in a different city and shares an apartment with some friends. Dysfunctional elements appear in the family relationship. She is ambivalent in relation to them. According to her own words, Susan loves her family. She also needs their continuous approval for every action. There is a great dependence on her father and the desire to be liked by him, as a child she was "daddy's little girl". Her mother was always concerned about her own diet, about being thin. Susan describes herself as someone obsessive and suffocating who even now that she lives independently calls her continuously to ask her what she eats, what she wears, and what she does.

She has great difficulty connecting with her breath, she feels that it stops at the level of the diaphragm and that it cannot flow. In one session she mentions that she feels a lot of anger inside herself (but she doesn't know why), and points out the exact place where her breathing stops.

She moves the arms lightly, but there is no integration at the torso level. During one of the sessions, she says: "I am terrified of being alone, that no one wants to be with me for pleasure, that no one likes me." And she adds "I feel anguish when I am alone at home and have to go out to see people."

One day I proposed to use the materials to build a house in which she could feel comfortable, in which she would like to stay. I offer her a box to put what she doesn't want in there. She plays with the cushions and blankets and creates a soft structure in which she ends up getting into, curling herself into a ball and starts rocking. She covers herself with a blanket. She spends a lot of time in that position. She starts crying. After a while, she removes the blanket that covered her, takes a cushion and leaves the house. The steps are firm and direct. Then

she takes several of the objects and throws them at the box in silence. She cries again, but now it's a softer cry. She tells me: "I realize that I can be my home". It is a very important moment in the process, and from there, we began to work on her poor self-concept and emotional dysregulation, in particular, identifying the origin of the anger and fear and expressing them in a healthier way.

4. Conclusions

Eating disorders are a serious problem that has increased markedly in recent decades, even more so after the pandemic caused by COVID-19. They generate great suffering to patients and their families, and on numerous occasions, and despite interventions, relapses are recurrent. It is necessary to work in an interdisciplinary way, integrating different approaches rather than those traditionally used. Creative therapies, and in particular, dance movement therapy through body awareness, motor patterns and symbolism that appears in spontaneous movement, deserve greater presence in the therapeutic field. The DMT approach enables access to non-conscious content and work on emotional regulation and restoration of secure attachment.

Although more rigorous research is needed, studies have demonstrated its efficacy in reducing anxiety, improving body image, increasing vitality.

This paper reports on the influence DMT has made on identification of characteristic movement patterns in ED (Hornyak & Baker, 1989a), on the effectiveness of DMT in reducing psychological difficulties and anxiety in ED, acquiring a more realistic body image, increasing self-esteem, reducing alexithymia and improving the quality of relationships.

Through the mentioned vignettes, it is possible to draw conclusions that the conducted group meetings made it possible to work on the dynamics of the group itself, its formation and development through the process. A closed group enabled members to develop similarly. Although at the beginning of the therapeutic process the participants did not manage to move spontaneously and had difficulties with verbalization at the end of the session, after three months of work, the awareness of the body increased noticeably, trust was built in the space, with the therapist and the group, and the recognition and expression of emotions and bodily sensations was achieved.

By reviewing the research and three vignettes, it has been proven that DMT is a particularly valuable approach for achieving stronger self-confidence and self-esteem, rebuilding the self, awareness,

integration, better body image and body boundaries, better intra- and interpersonal competence, generally greater psycho- corporeal integration that enables patients to develop healthier relationships with themselves and with others. We are not separate mind and body. We are one. When the body is damaged, perhaps the only way to heal it is to look back at the body itself.

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