Psychotherapy in Eating Disorders

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Abstract: After a brief presentation of the diagnosis criteria for eating disorders - anorexia (AN) and bulimia nervosa (BN)- , the author has analysed the main psychological explanations as well as the results of recent research on certain personality traits of the patients suffering from these disorders. All these underlie the necessity of an integrative psychotherapeutic approach combining most of the times the cognitive-behavioural treatment, the systemic family treatment and hypnosis. After presenting some psychotherapeutic programs, methods and techniques, the author has illustrated them by presenting a clinical case.

***Key words*:** Eating disorders, bulimia, anorexia, psychotherapy

Introduction

The eating disorders most frequently mentioned in specialised literature but also by the practitioners dealing with their treatment are anorexia nervosa (AN) and bulimia nervosa (BN). Besides specific characteristics, the persons with such disorders also present a series of common characteristics. The debut of eating disorders occurs when those persons engage in a severe diet. These individuals are usually women (90%), concerned both with their figure and food consumption. Both the people with AN, and the ones with BN are afraid of becoming obese and have a distorted perception of their figure and weight. What differentiates them is that the persons with AN manage to win the fight against kilograms, with a weight at least under 85% of the weight considered normal according to height and age.

Anorexia nervosa

General description

The most obvious symptom of AN is the refusal to maintain the body weight within the acceptable minimum limits. Those suffering from this disorder have a weight of at least 15 % under normal weight (according to DSM IV); ICD defines this minimum weight according to the body mass index – equal to or less than 17.5 kg/m^2. The great fear of gaining weight of individuals suffering from anorexia is the most important reason for excessively supervising food consumption to the extent to which this disorder becomes lethal. Stimulated by the fear to gain weight and the distorted perception of their own body, the people suffering from AN usually start by losing weight by means of a hypocaloric diet; then they continue by increasing the restrictions, their diet continuing with small quantities of aliments

low in calories. According to DSM IV TR, the diagnosis criteria for AN include the following symptoms: maintaining the weight under 85% of the expected one, the intense fear of gaining weight and becoming obese, a distorted perception of their own body, the consecutive absence of at least three periods (amenorrhea). The persons with AN seldom live the feeling of power given by the capacity to control their desire to eat and their distorted perception on the body does not allow them to notice the disproportion between their bones and their body mass.

Subtypes of AN

Although generally, when we think about AN, we immediately associate it with the restrictive type, there is also another type, characterised by overeating followed by purgation. This restrictive type maintains a low weight by a restrictive diet, long fasting, excessive physical exercise. Those belonging to the second type are engaged in excessive eating behaviour followed by purgation (self-induced regurgitation, laxatives). Some persons do not "stuff" themselves literally, but even if they eat small quantities of food, they engage in a forced process for evacuating the aliments ingested.

Prevalence, evolution and comorbidity

Approximately 1% of the population can be diagnosed with AN during their lifetime, although indices show that this tendency is increasing. This disorder appears mostly in women (90%) and is more accentuated in teenagers from gymnasium and high school classes. Nevertheless, the excessive preoccupation for the figure did not only lead to the increase in the AN frequency, but also to its spreading among most of the social categories and ethnic groups. The classic starting age is comprised between 1 and 18 years old. The best prognosis is in the cases starting at the beginning of adolescence. The recovery rate is low, with only 10% completely recovering, while approximately 50% of the patients partially recover. Approximately half the anorexic women later tend to develop bulimia (Beumont & Touyz., 2003; Reijonen, Pratt, Patel, & Greydanus, 2003).

The AN evolution is somehow unpredictable; nevertheless, it can be precipitated by certain stressful events. While some persons die after a first episode, others develop a chronic evolution, with variations in body weight, falls and various health problems. During the first five years, many individuals with AN restrictive type can develop a behavioural pattern closer to the overeating/ purgation type. If this transition is accompanied by a sufficient increase in weight, then the diagnosis can be changed to BN. Uncontrolled, chronic starvation and weight loss can lead to severe dehydration and an electrolytic unbalance requiring hospitalisation. Among the people needing hospitalisation, mortality is extremely high (10%), determined either by suicide, an electrolytic imbalance or other medical complications.

AN is associated with depression, irritability, anxiety, social seclusion and insomnia. Moreover, obsessive compulsive manifestations are met, since anorexics are highly concerned with food. The lack of control of the impulses is frequent in

the overeating / purgation eating type. Anxiety (75%), depression (73%) and personality disorders (74%) are the main comorbid psychological disorder. (Fassino, Pierò, Gramaglia & Abbate-Daga, 2004; Hinton & Kubas, 2005; Rogers & Petrie, 2001).

Bulimia nervosa

General description

The main characteristic of BN is the bulimic cycle that includes compulsive overeating followed by methods designed to prevent weight gain. The diagnosis criteria for BN include recurrent episodes of overeating, frequently followed by counterbalancing strategies for preventing weight gain. Overeating and counterbalancing behaviours occur at least twice a week over a three month period; moreover, self confidence is highly influenced by weight and figure.

Subtypes of BN

According to the counterbalancing behaviours enacted after compulsive food ingestion, we can identify two subtypes of BN: *The purgation type* (self-induced regurgitation, laxatives, diuretics) and *the non-purgation type* (excessive fasting, excessive physical exercises, etc. Due to the feeling of guilt and shame associated with overeating and purgation, the persons suffering from bulimia can be extremely difficult to identify. Overeating occurs in private places and the aliments are, very often, eaten rapidly. The precipitating circumstances of BN can include depression, stress factors, irritability, tenseness and long term starvation (fasting).

Although bulimics are engaged in counterbalancing behaviours for eliminating calories, the practice of repeatedly inducing regurgitation has some adverse effects that prevent them from reaching their objective. From a physical point of view, the acids in the stomach can deteriorate the esophagus and erode tooth enamel. Research in the field has revealed that regurgitation makes people feel less satisfied than when they don't cause themselves regurgitation. Therefore, bulimics are caught in a cycle that gives more intense sensations of hunger and increases the risk of repeating the excessive eating / purgation episodes (Maj, Halmi, Lopez-Ibor & Sartorius., 2003; Treasure, Schmidt & van Furth, 2003).

Prevalence, evolution and comorbidity

The prevalence of BN during a lifetime is of 1-3%, and the ratio between men and women is 1 to 10. The debut occurs later than in the case of AN, bulimia usually occurring towards the end of adolescence and at the beginning of adult age. The evolution is usually chronic, with come-backs and fall-backs. Most bulimics present weight variations, but they generally remain within the normal weight limits in relation to height. The comorbid disorders are similar to the ones met in AN (Beumont & Touyz, 2003; Reijonen et al. 2003).

Psychological conceptualisations of eating disorders

Various schools and psychological theories conceptualise eating disorders differently. The first psychoanalytical theories in this field emphasize the role of the separation-individuation crisis and suggest that AN and BN reflect a fear of reaching maturity (Rogers & Petrie, 2001) while, subsequently, the theoreticians extend the theoretical perspectives over those disorders including developmental deficiencies and underline the variety of neurotic conflicts expressed through the body (Berghold, Karena & Lock, 2002; Maj, et al. 2003).

The psychological theories that have had the most influence on the therapy of eating disorders are the cognitive behavioural therapies. In brief, these theories consider that the restriction of food ingestion, characterising the start of many eating disorders, has two main origins which can be discussed: 1) The need to control life which is transferred to the control of the eating behaviour; 2) The overestimation of the figure and weight in the case of the persons influenced by their look. They both lead to a restrictive diet. Subsequently, many other processes interfere maintaining the eating disorders: social seclusion, compulsive food ingestion determined by an extremely restrictive diet, the negative effects of excessive and compulsive eating on the image of one's own body and the feeling of self-control (Cooper, Wells & Todd, 2004). These ideas are confirmed by Shafran & Robinson (2004) who consider that an overestimation of food ingestion, weight and figure, leads to specific cognitions constituting the psychopathologic nucleus of the eating disorders.

An important role in the psychological mechanism of these eating disorders is held by the image that patients project over the future. Godley, Tchaturia, MacLeod & Schmidt (2001) assert that the anorexics generally have a positive image of the future, being nevertheless concerned with their health and interpersonal relations, while the bulimics have a negative image of the future, characterised by fears concerning their own health. To conclude, the positive aspects anticipated can, to a certain extent, maintain the anorexia although these patients are highly concerned with the possibility of some negative results. Bulimics are, in general, hopeless about their future.

The sociocultural theories emphasize the influence of the social messages about the ideal weight and figure and gender stereotypes in the development of the behaviour and the beliefs associated to the eating disorders, while the feminist theories notice the importance of the ideal roles and the feminine personality traits as predisposing factors (Hinton & Kubas, 2005; Reijonen et al. 2003; Walcott, Pratt & Patel, 2003).

Family dynamics can play a major part in precipitating and maintaining the eating disorders. The mothers of the patients with eating disorders tend to be perfectionists and are also concerned with their weight. Bruch (1974) state that while the parents efficiently adapted to the role of parent, they are sensitive to the needs of their children and respond appropriately to their biological and emotional

needs; inefficient parents respond inappropriately to these needs, feeding the children when they are not hungry, using nutrition as a solution against children's anxiety and irritation. In this case, the inadequate response has two consequences: It stabilises a certain pattern of the internal signals activating hunger, and it correlates food with comfort. The role of the family environment in the aetiology of eating disorders is also highlighted by the finding that there is a specific risk of anorexia in families formed by persons with anorexia, whereas for the persons with bulimia there is a tendency for substance abuse, emotional disorders and obesity. Minuchin, Rosman & Baker (1978) describe four characteristics of anorexic families: highly inclusive structure, overprotection, rigidity and conflict denial. They assert that these families are excessively concerned with the facade, and are extremely reserved in exerting their influence. In such a psychological environment, extremely narrow for independent development, anorexia gives the adolescent women the ability to control food ingestion, delaying at the same time the moment they reach maturity (the development of feminine characteristics) and increasing their dependency.

Other studies referring to the relationship between family environment and eating disorders highlight different patterns in family functioning in the two categories of disorders: involvement in the families of the persons with anorexia and hostility in the case of the families of the bulimic persons (Honey & Halse, 2006; Maj et al. 2003). Scarano & Kalodner-Martin (1994) state that individuals can be situated on a continuum of eating disorders, respectively people that eat normally, persons concerned with their weight, those following a long term diet, ones with purgation behaviours, persons under the threshold of bulimia, and people suffering from bulimia. These individuals present similar psychological characteristics, that is, dissatisfaction caused by the image of their own body, low self-esteem, the fear to gain weight, and differ only by the frequency and severity of these symptoms. From this perspective, Tylka & Subich (2002) also state that most psychological risk factors (inefficiency, lack of self-confidence, and the level of confidence in weight control techniques) are linearly correlated to this continuum of eating disorders.

Besides these various theoretic perspectives, we discovered the common idea that most persons with eating disorders share a few psychological characteristics: The feeling of inefficiency and the lack of self-control (an external place of control), increased obsessiveness, a tendency towards addiction, low assertiveness, and internal hostility (unexpressed) (Rogers & Petrie, 2001).

Raised in a society which valorises the ideal figure, women tend to be more and more concerned, even obsessed, with aspects related to weight and diet. Because they are educated to repress their own needs in relation to others; they accumulate several frustrations which turn into hostility oriented towards their own body.

The psychotherapy of eating disorders

Based on an important magazine of specialised literature in the field of anorexia nervosa, Treasure & Schmidt (2003) reached the following conclusions: there are no solid arguments to assert that a particular psychotherapy is more efficient than others, the antidepressants associated to psychotherapy do not lead to better results and no study recommends the use of neuroleptic medication (p. 208). The same authors assert that in the field of bulimia, most studies have verified the efficiency of the cognitive behavioural therapy that have proven to be at least as efficient or even more efficient than other psychological interventions; pharmacotherapy is less efficient than psychotherapy, while a combination between the psychological and medical interventions seems to be more efficient than each type of therapy considered separately.

The main elements of the psychotherapeutic programs based on the cognitive therapy paradigm are: the awareness of the eating disorder, the development of some appropriate objectives and attitudes concerning body weight, the correlation of the objective's accomplishment with certain rewards and advantages, the monitoring of the eating behaviour by an adult (in order to avoid purgation), the stimulation of the awareness of the nonadaptive cognitive patterns (perfectionism, negative thoughts, etc.), the learning of some relaxation techniques and the focus on preventing fall-backs. Moreover, the treatment can tackle the potential stress factors (family, colleagues) as well as any comorbid problems (anxiety, depression, etc). The programs of cognitive behavioural therapy can be applied individually or in group, and, usually, also include the patient's family (Heller, 2001; Krautter & Lock, 2004; Patel, Pratt & Greydanus, 2003; Phillips, Greydanus, Pratt, & Patel, 2003; Stein et al. 2001; Treasure et al. 2003).

With most of my patients, together with other psychotherapeutic methods and techniques, I successfully used behavioural prescriptions that aim at modifying the habits that preserve the eating disorders:

- Compulsive overeating generally taking place in front of the TV is forbidden; in such situations the person is not entirely aware of the quantity, or the taste of the ingested food. In order to preserve the ritual, I recommend replacing the food eaten in front of the TV with herbal tea;
- Five to seven meals per day with small quantities of food at every meal; in this way the development of the incriminated cycle is avoided in maintaining the eating disorders: starvation – frustration – control reduction – overeating – self-blaming – starvation ....; in this case I use the pendulum or sponge metaphor: if we strongly unbalance a pendulum by moving it to the right, when released, it will be projected with the same force from the opposite side; if we firmly squeeze a sponge and then we introduce it in water it may absorb more water than before;

- Eating will take place in an ambiance as pleasant as possible and the plate will contain the quantity of food considered by the patient being as reasonable; if after finishing this meal the patient wants more, (s)he is recommended to do this only after 20-30 minutes (usually after this period of time satiety is already achieved);
- The patient will eat small bites and will chew them thoroughly; in this way, (s)he will be able to enjoy, to a greater extent and for a longer time, the pleasure produced by the ingested food; in addition, if eating lasts longer, it is possible that satiety be achieved even before the patient finishes eating what (s)he had planned to eat in the first place
- In order to avoid compulsive weighing, the scale will be stored in the most difficult place to reach (thus, the time necessary for activating the self-control ability is attained); Weighing is recommended once a week!

The eclectic therapeutic programs, often designed around a cognitive behavioural inspirational nucleus, are, due to their increased flexibility, more and more used in clinics specialized in the treatment of eating disorders. In a recent study, Gerlinghoff, Gross & Backmund (2003) brought arguments in favour of the efficiency of such a program which proposed to stimulate the patient's motivation, self-determination and responsibility by using his/her main resources: will, energy and self-discipline (for example, bulimia requires intelligent planning, energy and organizational habits for leading a secret life!). The therapeutic program drawn in four phases (the motivation assessment and stimulation, the ambulatory phase, the self-management phase and the separation phase) combines during the second phase the following types of psychological intervention: cognitive-behavioural therapy, nutritional therapy, art therapy, body image therapy, social training.

For each type of therapy, the patient's motivation to participate in therapeutic labour is a decisive factor for the success of the therapy, moreover, in the case of eating disorders where food indigestion has immediate positive consequences, whereas the therapeutic prescriptions have positive consequences on the long run and are often perceived as being only possible. This is why the evaluation and stimulation of the patients' motivation play an important role in the above-mentioned therapeutic program. The other elements of the therapeutic program have in view the main incriminated factors in the aetiology and maintenance of the eating disorders: The distorted cognitions regarding the self, including the body, negative emotional mood (depression and anxiety), social factors, the ability of self-control, eating habits etc.

More and more scientific research relates hypnotisability with eating disorders, as well as with certain personality traits (for example, dissociation) of patients suffering from these disorders. In clinical literature, Oakley & Frasquilho (1998) state that most of the research results show that the restrictive anorexics are normally or slightly more hypnotizable, whereas the bulimics are significantly more hypnotizable than the usual and present increased dissociative tendencies.

Even with respect to the non-clinical population with normal weight there is a positive correlation among hypnotisability, dissociative tendencies and the attitude towards food ingestion. Results have also shown that hypnotisability is particularly related to the restrictive diet, whereas the dissociation is related to compulsive overeating. This last aspect can explain the overeating components met in the case of eating disorders. These authors consider that patients with restrictive eating behaviours are more responsive than the non-restrictive ones to suggestions regarding the increased size of the body, which may partially explain at least the distortions of the body image met in the case of eating disorders.

All research on the correlation between hypnotisability and eating disorders have stimulated the development of the therapeutic program which combines hypnosis with cognitive behavioural therapy. Thus, Coman & Evans (1995) support the necessity of using hypnosis during certain eclectic therapeutic programs. There can be techniques used such as age progression, age regression and ideomotor signalling, in order to find the origin of the distorted cognitions and of the emotional conflicts which hasten the emergence of eating disorders. Hypnosis may also be used for treating subjacent problems: self-confidence, low self-esteem, depression, as well as anxiety and social phobia related to anorexia. In this sense, techniques such as self-talk, the secured imaginary place, etc can also be used.

Godoy & Torres (1999) also asserts that a combination between behavioural therapy and hypnosis seems to be more efficient than behavioural therapy alone. The most widely used techniques seem to be relaxation, self-control by means of hypnosis, the stimulation of physical activity, techniques for strengthening self-esteem and a positive image of one's own body, the motivation, strengthening and exploration of the ambivalence concerning change.

Torem (2001) makes a very useful classification of the main hypnotherapeutic techniques that can be used in the treatment of eating disorders:

- The techniques for *strengthening the ego* are a part of almost every hypnotherapeutic intervention; in the case of eating disorders, they aim at increasing self-control, self-acceptance, comfort in relation to oneself and the others, etc.

- C*ognitive reframing and restructuring*; the hypnotic trance facilitates the development of alternatives and new perspectives on old problems; the aim of the treatment can be reformulated in terms of power and resource gain and not in terms of weight gain; during the trance induced by the therapist or during the trance self-induced by the patient, one can use suggestions of the type: "For me and my body excessive eating, purgation, starvation are poison", "I need my body in order to live", "If I want to live my life totally, I owe it respect and protection".

- A*ge progression*; the patient is oriented towards visualising the desired future in a dissociated and associated manner (professionally, socially, interpersonally, near the person they love, etc.) and are encouraged to send from

this ideal future useful advice and encouragement or to identify the necessary steps in order to reach this future. This technique is very useful in dealing with the adolescents who are anyways concerned with their future.

- *Metaphorical prescriptions*; the metaphors or the metaphorical prescriptions determine the patients to experience the success and acquisition of self-control as well as the development of new alternatives and options. Here are some useful metaphorical prescriptions: 1) Realising the map of a journey from point A to point B; the map has to contain at least two alternatives as well as the analysis of the advantages and the disadvantages of each alternative; 2) Redecorating their room / house; 3) Buying new clothes; 4) Changing their glasses or contact lenses; 5) Adopting a pet (dog, cat); 6) Solving a puzzle; 7) Growing a plant (tomato), following its growing and development, and picking the fruit only when it reaches maturity.

Clinical case

Clinical conceptualisation of the case

The patient aged 15 is brought to therapy by her aunt (her mother's sister) and grandmother (*which is significant for the relationship between the patient and her mother*). Obviously, the patient was in a severe stage of anorexia. Initially, the patient didn't even want to reveal her weight. She was however disturbed by the fact that the last doctor who saw her suggested she gain 20 kilos. "Can you imagine what my body would look like?" she said with an ample movement of her arms marking the limits of a huge body.

Her anamnesis highlights the following significant aspects: Her father, a sailor, abandoned the family when the child was 3-4 years old. After this event, the little girl became the focus of the entire family – mother, aunt, grandmother. A few years later, when the mother remarried, the girl entered into a competition with her step-father (to whom she referred as "that guy") for her mother's love; she constantly asked her mother whom she loved the most. In this competition, the refusal to eat became a frequently used means. She had amenorrhea for some time. The patient was obviously concerned with her figure and told us that she wanted to become a fashion model. She practised a highly restrictive diet, especially in the first part of the day, (since she was afraid of gaining weight); in the evenings she ate more, although still not enough.

During the first interview, the aunt (who owned a fitness center!) and the grandmother expressed several times, in the presence of the patient, the desire that the girl should eat more, which made her reply that if this was the aim of the treatment, she was not willing to cooperate! "Maria is old enough to decide for herself what and how much she needs to eat", I said. "From now on no one is allowed to force her to eat more!" (*This statement was aimed at decreasing the competition behaviour of the patient and placed her in the impossibility to use the symptom as affective "blackmail", since her eating behaviour was no longer the*

interest of her family). Later, the interview focused on the analysis of her school results which were obviously decreasing due to the precarious physical state in which she was. In fact, the low school results were the explicit reason accepted by the patient in requiring therapeutic help.

We considered that anorexia was maintained by the multiple advantages it brought to the patient in the family environment – affection, attention, motivation for the lowering school results etc, as well as the competition she developed with the other family members. Among the etiologic and maintaining factors, we mentioned the distorted image that the patient had of her own body, a negative image of herself accompanied by a feeling of abandonment determined by her father's leaving, as well as the fact that the verb "to gain weight" was obviously a negative excuse against any attempt to modify the diet aimed at gaining weight.

Psychotherapeutic techniques

The Drawing of her own body. After the patient told me that she wanted to become a fashion model, I asked her to draw her own body as it looks now and as she would like it to look in the future. The drawing is given in the annex: In the present image of the body, all its elements are drawn with straight lines while the future image presents a harmonious form made up of curved lines. Both drawings show the body without a head. We established, symbolically, both the starting point and final objective of the treatment.

The establishment of a positive shelter concerning weight loss. I told the patient that the final aim of the treatment is not to fatten but to shape her body. To this aim we will use the therapeutic model of the four "M": **M**iscare, **M**âncare, **M**asă **M**usculară! (Movement, Food, Body Mass)

The metaphor. During the hypnotic trance I told her the following metaphor: "Imagine you are driving the best car you have ever seen, on a highway that could lead you to the city of your dreams, where you could become whatever you want. But as marvellous as these all are, you're never going to go there if you don't use the fuel that the car, and **yourself** need!"

Behavioural prescriptions. She will eat often and will eat small quantities of food, five meals a day. (*The ingestion of a big quantity of food that determines the bulging of the stomach accentuates the disorder that affects almost every person suffering from anorexia*). This prescription was also correlated with the metaphor shown above: "*And thus your body won't run the risk of running out of fuel!"* The aim of weight gain was established for 0.500kg/week. She will be weighted once a week. Physical activity: One hour walk daily. "Making friends with her own body": She will look at herself in the mirror at least twice a week in order to identify the part she likes the most.

Hypnotic trance. During the hypnotic trance we used suggestions such as: *"You feel more and more comfortable in your own body!", "You begin to understand more and more the signals emitted by your body!, "You need a strong body in order to reach your objectives!", "Starvation is poisonous for your body!".* These

suggestions were self-administered by the patient in the first person, in a ritualised form (repeated three times each). We frequently used age progression in order to visualise her own body in a situation in her future as a fashion model.

Evaluation: After 3-4 months in which the patient, more and more, adopted an adequate diet, at the same time with the involvement in the practice of all the techniques presented and weekly sessions of psychotherapy, we asked her to draw her body again in the two hypostases: Present and future. The two drawings presented similar forms which made me think that the patient will start to control her body weight. And this indeed happened. But this time, she adopted a healthy means of control, the main method being practicing physical exercises of moderate intensity, aimed not at losing weight but at maintaining the weight she had, at body shaping. We decided together to put an end to the therapy. The news I had a year later on the patient confirmed the absence of eating disorders.

Conclusion

The eating disorders' symptomatic picture is fairly distinguishable, composed by excessive worries about body figure and destructive strategies to prevent weight gain like fasting or purging. The aim of this present paper was to review the most important information we actually have on this type of pathology. We intended, as well, to illustrate some of the most efficient techniques in dealing with patients suffering from anorexia or bulimia. Although the factors influencing the development of eating disorders are complex and quite diverse, the intervention in therapy can successfully combine behavioural approaches, hypnosis, and systemic therapy. These modern approaches will allow us to advance in the understanding and support for patients with eating disorders.

Reference List

American Psychiatric Association (2003). *DSM – IV – TR.* Bucureşti: Editura Asociaţiei Psihiatrilor Liberi din România.

Berghold, M. Karena, Lock, J. (2002). Assessing guilt in adolescents with anorexia nervosa. *American Journal of Psychotherapy,* 56:3, 378-390.

Beumont, P. J.V., Touyz, St. W. (2003). What kind of illness is anorexia nervosa? *European Child & Adolescent Psychiatry*, 12, 20–24.

Bruch, H. (1974). *Eating disorders*. London: Routledge & Kegan Paul.

Burns, M. (2004). Eating Like an Ox: Femininity and Dualistic Constructions of Bulimia and Anorexia. *Feminism Psychology,* 14; 269-281.

Claes, L., Vandereycken, W., Luyten, P., Soenens, B., Pieters, G., Vertommen, H. (2006). Personality Prototypes in Eating Disorders Based on the Big Five Model. *Journal of Personality Disorders.* Aug; 20:4, 401-416.

Coman G., Evans B.(1995) Clinical update on eating disordersand obesity: implications for treatment with hypnosis. *Australian Journal of clinical and Experimental Hypnosis*, 23 (1), 1-13.

Cooper M. J., Wells, A., Todd, G. (2004). A cognitive model of bulimia nervosa. *The British Journal of Clinical Psychology*, 43, 1-16.

Degun-Mather, M. (2003). Ego-state Therapy in the Treatment of a Complex Eating Disorder. *Contemporary Hypnosis*, 20: 3, 165–173.

Fassino, S., Abbate Daga, G; Amianto; F. Leombruni, P; Fornas, B., Garzaro, L., D'Ambosio, G. (2001). Outcome predictors in anorectic patients after 6 months of multimodal treatment. *Psychotherapy and Psychosomatics*, 70: 4, 201-208.

Fassino, S., Pierò, A., Gramaglia, C., Abbate-Daga, G. (2004). Clinical, Psychopathological and Personality Correlates of Interoceptive Awareness in Anorexia nervosa, Bulimia nervosa and Obesity. *Psychopathology*, 37, 168-174.

Gerlinghoff, M., Gross, G., Backmund, H. (2003). Eating disorder therapy concepts with a preventive goal. *European Child & Adolescent Psychiatry [Suppl 1]*12, 72–77.

Godley, J., Tchanturia K., MacLeod, A., Schmidt, U. (2001). Future-directed thinking in eating disorders. *The British Journal of Clinical Psychology*, 40, 281-296.

Godoy, Torres P.H. (1999) The use of hypnosisin posttraumatic stress disorders, eating disorders, addictions, depression and psychosis: an eight-year review (part two). *Australian Journal of Clinical Hypnotherapy and Hypnosis*, 20(2), 73-85.

Guilfoyle, M. (2001). Problematizing Psychotherapy: The Discursive Production of a Bulimic. *Culture Psychology*, 7, 151-179.

Heller L. D. (2001). Anorexia Nervosa: Treatment in the Family Context. *The Family Journal*, 9, 159- 163.

Hinton, P.S., Kubas, K. L. (2005). Psychosocial Correlates of Disordered Eating in Female Collegiate Athletes. *Journal of American College Health*, 54:3, 149 -156.

Honey, A., Halse, C. (2006). The Specifics of Coping: Parents of Daughters with Anorexia Nervosa. *Qualitative Health Research*, 16, 611-628.

Hutchinson-Phillips, S., Jamieson, G. A., Gow, K. (2005). Differing Roles of Imagination and Hypnosis in Self-regulation of Eating Behaviour. *Contemporary Hypnosis*, 22:4, 171–183.

Krautter, T. H., Lock, J. (2004). Treatment of Adolescent Anorexia Nervosa Using Manualized Family-Based Treatment. *Clinical Case Studies*, 3, 107-123.

Lock , J., Le Grange, D. (2001). Can Family-Based Treatment of Anorexia Nervosa Be Manualized? *Journal of Psychotherapy Practice and Research*, 10, 253-261.

Maj, M., Halmi, K., Lopez-Ibor, J. J., Sartorius, N. (2003). *Eating Disorders.* Southern Gate, Chichester, West Sussex: John Wiley & Sons.

Mantle, F. (2003). Eating disorders: The role of hypnosis. *Paediatric Nursing*, 15:7, 42 - 45.

Minuchin S., Rosman B.L., Baker L. (1978). *Psychosomatic Families: Anorexia nervosa in context.* Cambridge, Mass.: Harvard University

McIntosh, V. W., Jordan J., Carter, F. A., Luty, S. E., McKenzie, J.M., Bulik, C.M., Frampton, C.M.A., Joyce, P.R. (2005). Three Psychotherapies for Anorexia Nervosa: A Randomized, Controlled Trial. *The American Journal of Psychiatry*, 162: 4, 741-747.

Newton, M. (2005). Exploring the Psychopathology of Anorexia Nervosa: A Mahlerian Standpoint. *Perspectives in Psychiatric Care*, 41: 4, 172-180.

Oakley, D., Frasquilho, F. (1998). Hypnotic susceptibility, or F-bias: Its relevance to eating disorders. *Contemporary Hypnosis*, 15: 1, 40-51.

Patel, D. R., Pratt H. D., Greydanus, D. E. (2003). Treatment of Adolescents with Anorexia Nervosa. *Journal of Adolescent Research*, 18, 244-260.

Pederson, M. M., Binford, R. B., Fulkerson, J. A. (2000). Eating Disorders: Summary of Risk Factors, Prevention Programming, and Prevention Research. *The Counseling Psychologist*, 28, 764 -796.

Perosa, L. M., Perosa, S. L. (2004). The Continuum Versus Categorical Debate on Eating Disorders: Implications for Counselor. *Journal of Counseling and Development*, 82: 2, 203-206.

Phillips, E. L., Greydanus, D. E., Pratt, H. D., Patel, D. R. (2003). Treatment of Bulimia Nervosa: Psychological and Psychopharmacologic Considerations. *Journal of Adolescent Research*, 18, 261-279.

Reijonen, J. H., Pratt, H. D., Patel, D. R., Greydanus, D. E. (2003). Eating Disorders in the Adolescent Population: An Overview. *Journal of Adolescent Research*, 18, 209-222.

Rogers, R. L., Petrie, T. A. (2001). Psychological correlates of anorexic and bulimic symptomatology. *Journal of Counseling and Development*, 79:2, 178-187.

Scarano G., Kolodner-Martin, C.(1994) A description of the continuum of eating disorders: Implications for intervention and research. *Journal of Cunseling&Development*, 72, 356-367.

Schlosberg, S. (2005). Losing weight by HYPNOSIS. *Shape*, 24:11, 168

Shafran, R., Robinson, P. (2004). Thought-shape fusion in eating disorders. *The British Journal of Clinical Psychology*, 43, 399-408.

Stein, R. I., Saelens, B. E., Dounchis, J. Z., Lewczyk, C. M., Swenson, A. K., Wilfley, D. E. (2001). Treatment of Eating Disorders in Women. *The Counseling Psychologist*, 29, 695-730.

Steinhausen, H.C., Boyadjieva S., Griogoroiu-Serbanescu, M., Neumärker, K. J. (2003). The outcome of adolescent eating disorders. *European Child & Adolescent Psychiatry*, 12, 91–98.

Tiggemann, M. (2005). Television and adolescent body image: the role of program content and viewing motivation. *Journal of Social and Clinical Psychology*, 24:3, 361-381.

Torem, Moshe S. (2001). Eating Disorders – Anorexia and Bulimia, in: G.D. Burrows, R.O. Stanley, P.B. Bloom (eds), *International Handbook of Clinical Hypnosis.* (p.205 -219) New York, John Wiley & Sons Ltd.

Torres Godoy, P. H. (1999). The use of hypnosis in posttraumatic stress disorders, eating disorders, sexual Disorders, Addictions, Depressions and Psychosis: An Eight – year Review (Part Two). *Australian Journal of Clinical Hypnotherapy and Hypnosis*, 20: 2, 73 -85.

Treasure, J., Schmidt, U., van Furth, E. (eds) (2003). Handbook *of Eating Disorders.* New York, John Wiley&Sons.

Tylka T., Subich,I.(2002).Exploring Young women's perceptionsof the effectivenessand safetyof maladaptive weight control tehniques. *Journal of Cunseling & Development*, 80, 101-110.

Walcott, D. D., Pratt H. D., Patel, D. R. (2003). Adolescents and Eating Disorders:: Gender, Racial, Ethnic, Sociocultural, and Socioeconomic Issues. *Journal of Adolescent Research*, 18, 223 -243.

Waller, G., Ohanian, V., Meyer, C., Everill, J., Rouse, H. (2001). The utility of dimensional and categorical approaches to understanding dissociation in the eating disorders. *The British Journal of Clinical Psychology*; 40, 387- 397.

Weiss, F. (2000). Body Image, Eating Disorders, and Obesity: An Integrative Guide for Assessment and Treatment. *American Journal of Psychotherapy,* 54;1, 128-132.

Westen, D., Harnden-Fischer J. (2001). Personality profiles in eating disorders: Rethinking the distinction between Axis I and Axis II. *The American Journal of Psychiatry;* 158: 4, 547-562.

Wright, S. (2006). Test of Time: Review of Liebman et al.'s 'An Integrated Treatment Program for Anorexia Nervosa'. *Clinical Child Psychology and Psychiatry*, 11; 475-482.

Zubery, E., Binsted, N., Zifman, N., Jecsmien, P. (2005). Adolescents Resisting Treatment: Exploring the Resistance in Eating Disorder Patients to Treatment within the Family System. *The Israel Journal of Psychiatry and Related Sciences*, 42:3, 146-153.