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# THE CONTEXT FOR HAKOMI IN THE TREATMENT OF EATING DISORDERS

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This article is designed to be the first of a two-part series in the use of Hakomi in the treatment of eating disorders. I would like to describe the wider context of treatment in this first article, followed by a later article describing the applications of Hakomi principles and techniques for the treatment of women with eating disorders.<sup>1</sup>

I will generalize throughout this article. It is important to remember not all clients will fit the typical description. The purpose is to provide a "ball park" description that the therapist refines to include the unique features of each client.

Eating disorders include primarily anorexia nervosa and bulimia. Anorexia nervosa is the starving disease: young women starve themselves and become emaciated in the relentless pursuit of thinness. Bulimia is the binge-purge syndrome: women are often normal-weight individuals who vomit or use purgatives or laxatives after binge-eating. Sometimes they alternate between bouts of overeating and deprivation diets.

Bulimia and anorexia nervosa are complex disorders that are caused and then maintained by various social, psychological and biological factors. Eating disorders are now epidemic among college-age women. Because research and treatment advances are relatively recent, therapists and clients are often relatively unfamiliar with many areas of treatment. I hope this article will provide an awareness of the complexities involved in

the treatment of eating disorders and an aid in evaluating if, and what kind of, additional training may be helpful in developing an approach to psychotherapy with this population. I also hope this article will contribute to an understanding of a context in which Hakomi can be an effective therapy with bulimics and anorectics.

It is important to realize that no single treatment is apt to be sufficiently comprehensive to address the problems inherent in anorexia nervosa and bulimia (Lacey, 1985; Bruch, 1985; Johnson, 1985). Exposure to diverse treatment methods--individual, medical, nutritional, and family--are usually needed.

The reader may be disappointed that there is so much to consider regarding treatment context;<sup>2</sup> however, the treatment of eating-disordered clients requires a broad multidisciplinary perspective. It is believed that without careful evaluation and multidisciplinary support, people with eating disorders often seem to terminate prematurely and deteriorate in their eating behavior, with further diminished self-esteem and serious discouragement (Lacey, 1985; Hall, 1985).

A description of the evaluation procedure and its rationale are outlined here. Evaluation almost invariably relies on consultation with other treatment specialists.

## MEDICAL EVALUATIONS

A nonmedical therapist working with an eating disorder client needs a good working relationship with a physician skilled in evaluating medical problems with eating disorders. James C. Sheinin, M.D., has written a good article for physicians unaccustomed to evaluating eating-disordered individuals.<sup>3</sup>

Electrolyte disturbance is probably the most dangerous complication of vomiting and laxative abuse. Occasionally, clients attempt to induce vomiting with an emetic like Ipecac. They may also use diuretics. Again, the biggest danger is electrolyte imbalance, which may cause weakness, tiredness, constipation, and depression. In extreme cases, they may result in cardiac arrest and sudden death. These abnormalities are related to degree of low weight and the frequency of self-induced vomiting, combined with laxative, emetic, and diuretic abuse (Garfinkel and Garner, 1982; Adler, et al, 1980; Andersen, et al, 1985).

A physician will need to assess whether weight gain is essential before effective psychotherapy can proceed. A weight loss approaching 25 percent of original body weight will often signal the need for hospitalization for anorexia. Hospitalization may also be necessary for bulimics who show a high degree of dietary chaos.

### DIAGNOSTIC ASSESSMENT

Eating disorders are spectrum disorders. Clients range from severe personality disorders (often borderline and hysterical) to relatively adjusted individuals. Borderline personality features are especially common among laxative users (Wooley, S. and Wooley, O., 1985).

Bulimic clients especially sometimes have histories of multiple substance abuse, various impulse-dominated behaviors such as shoplifting, promiscuity, self-abusive behavior, or unremitting binge-purge cycles. Clients with severe character disorders, borderline or narcissistic, who have been bulimic or anorectic for several years may

not be able to give up their symptoms for a long time until extensive therapeutic work has been accomplished. These clients tend to respond most favorably to highly structured, directive, supporting interventions aimed at life management. Symptoms generally remit only after the client feels securely held by a treatment setting (Wooley, S. and Wooley, O., 1975).

Therapists need to evaluate whether symptomatic eating behavior is only one aspect of a much more complex treatment picture. The therapist will need to consider not only the degree of psychological disturbance but also his or her own level of skill in determining whether Hakomi is the most appropriate immediate psychotherapy intervention.

### ASSESSMENT OF DEPRESSIVE SYMPTOMS

Depression frequently coexists with eating disorders. Assessment has two major complications. First, evaluation of depressive symptoms is complicated by the direct effects of starvation and electrolyte imbalance. Secondly, there is reason to believe that primary affective disorders frequently coexist with eating disorders (Piran, et al, 1983; Cantwell, et al, 1977). A primary affective disorder is a depressive state characterized by vegetative symptoms such as mood variability, persistent fatigue, sleep difficulty, frequent crying episodes, irritability, restlessness, and appetite disorder.

Frequently, a primary affective disorder is responsive to antidepressant medication. Both tricyclic antidepressants and monoamine oxidase inhibitors have been reported to be successful as an adjunct to treatment with eating disorder clients (Needleman and Waber, 1976; Pope, et al, 1983). This is a controversial area, but generally, trial on antidepressant medication should be reserved for clients where there is reason to believe that depressive symptoms would persist after weight and eating patterns are normalized (Garfinkel and Garner, 1982).

Given that depression frequently co-exists with an eating disorder, evaluation needs to address degree of suicidal ideation, the extent of suicide risk, and to what degree intervention addressing suicide potential needs to be a part of treatment.

#### FAMILY ASSESSMENT

In most treatment programs, family therapy is a requirement for treatment of any anorectic or bulimic who is 18 or younger (Wooley, S. and Wooley, O., 1985; Schussetz, et al, 1985; Sargent, et al, 1985). Especially when the client lives at home, recovery may be impossible without addressing patterns of family interaction.

Parents generally have guilt, anger, and feel overwhelmed by the eating disorder. They want help but are tired of the efforts and need relief and guidance. Issues concerning the whole family often include communication skills and effective parenting (Schwartz, et. al, 1985). There is often a facade of "super-togetherness" and stability that covers deep discontent on the part of one or both parents (Garner, et al, 1985).

The parents often need help with their own anxieties to permit their daughter more freedom. When the daughter shows true signs of developing independence, parents often comment, "If only she could again be the girl she once was," overlooking that she was unable to face growing up and living as an adult (Bruch, 1985).

Often family therapy or an assessment of family dynamics is helpful in assessing underlying beliefs. Often there is an understanding of the daughter's need to provide happiness for her parents who could not tolerate her growing up and leaving home. There is often a need for dealing with disillusionments with parents who have interfered with individual self-expression and with conflicts that have stood in the way of individuation.

#### TESTING (OPTIONAL)

The Eating Disorder Inventory is the

first valid and reliable test specifically for eating disorders. It gives a differentiation into bulimic and anorectic categories; it also gives measurements of categories such as ineffectiveness and fear of maturation, which are central theoretical constructs of the illness (Garner, et al, 1983).

#### THE PSYCHOEDUCATIONAL COMPONENT OF TREATMENT

Many psychotherapists and clients are least familiar with this area of treatment, yet the importance of the therapist's understanding of these psychoeducational factors cannot be overemphasized. Some clients improve simply through understanding more about the social and biological contradictions with which they have been struggling (Garner, et al, 1985).

It is important to understand the enormous pressures on women to diet in the pursuit of a thinner shape and how these have become more unrealistic and destructive. The health benefits of slenderness have been profoundly overemphasized. Dieting, the major treatment for obesity, may also be the major cause for obesity (Wooley and Wooley, 1985) and it certainly seems a major cause for bulimia (Garfinkel and Garner, 1982).

Studies on psychotherapy have indicated that treatment has often led to an increase in well-being, with little impact on overt eating symptoms. For example, because of binge eating and vomiting, the client often has little idea of normal dietary intake (Lacey, 1985). In the recovery process, due to this distortion of appetite and satiety, the body needs to be retrained to experience satiety. Knowing this provides hope and gives the client a road map (Wooley and Wooley, 1985). Physical symptoms accompanying recovery must also be discussed and understood. These symptoms include dramatic weight shifts due to the rehydration and an apparent disturbance in the regulatory mechanism for food retention, which seems to correct itself with time. These psychoeducational principles in the treatment of bulimia and anorexia nervosa need to be incorporated

with any psychotherapy method. I find it most useful to present the psychoeducational principles within a context of a group specifically for eating-disorder women.

It is important that the effects of social and biological pressures be integrated in treatment so that the client does not experience the profound loss of self-esteem, self-criticism, and blame that come from being unable to control her weight by "will power." It is important that she understand the extent to which she is fighting an impossible battle, largely based on misinformation. The therapist working with eating disordered individuals will need some specialized knowledge. The scientific literature relating these points is reviewed in some detail, followed by specific practical recommendations for overcoming bulimia and related disorders (see Garner and Garfinkel, 1985, pp. 513-572).

#### GENERAL ISSUES IN PSYCHOTHERAPY

Bruch and Selvini-Palazzoli (1974) described how early disturbances in mother-infant relationships contribute to the development of eating disorders. The mother seems typically rigid, overprotective and unable to respond to her daughter as an individual (Hall, 1985). The mother seems to lack the ability to empathetically "tune in" to her infant's needs, for example, for food or comfort. Needs and feelings are responded to inappropriately. The infant does not develop the essential groundwork for body identity with "adequate perceptual and conceptual awareness of her own functions" (Bruch, 1985).

During childhood, eating-disorder families generally do not know how to encourage exploring and sharing inner experience. When anxiety or depression occurs, it is minimized, ignored or smothered. Sometimes, childhood stresses meet with unempathetic responses. For example, "You're too sensitive--there's nothing to be upset about." "You're okay--don't worry about it." Such responses dismiss the child's anxiety. Often a child senses that what is important is not her own experience but rather not being a

burden to others. The foundation of the child's budding self or inner experience is not contacted, recognized, confirmed or taken seriously (Goodsitt, 1985). As a result, there is a diminished sense of self. Obedience and overconformity characterize childhood behaviors (Bruch, 1985).

The child grows up perplexed in trying to differentiate between disturbances in her body and in the world outside (Bruch, 1985). Ego boundaries are diffuse. There is little sense of separateness. Feelings of helplessness and lack of control predominate (Hall, 1985). With puberty, the future eating-disordered individual feels helpless under the impact of new bodily urges including increased hunger. In her fear, she overcontrols her needs. The effect is self-starvation often leading to bulimia (Bruch, 1985).

Intrapsychically, the eating-disordered individual typically feels terribly ineffective, incapable emotionally, labile, tension-ridden, desperately needful, unable to be alone with inner feelings (Goodsitt, 1985). She commits herself to never being a burden and tries to maintain her parents' well-being. She has a compliant, pleasing facade and cannot allow her wishes and needs to become important. With the onset of the eating disorder, these needs and wishes break through and she takes control of at least a narrowly defined world (Goodsitt, 1985). These general issues may provide some groundwork in forming a sense of "the child" and her core beliefs. In my own work, accessing "the child" has been a most powerful intervention.

#### ADDRESSING THERAPY ISSUES WITH HAKOMI

I would like to share some early thoughts of how I see Hakomi especially suited for addressing some of the problems described above. The principles underlying Hakomi address some aspects of eating-disorder disturbance in a profoundly direct and healing way. It is beyond the scope of this paper to apply the principles to the treatment of eating disorders, yet it seems important to mention two which seem the most

obviously important--mindfulness and mind-body holism.

Early childhood experiences have resulted in the child's failure to tune into inner experiences and learn about herself. Most eating-disordered behavior is compulsively determined by the urgent need to drown out tensions that exist because the client is not aware of her needs and desires and, therefore, cannot fulfill them (Goodsitt, 1985).

Helping the eating disorder client to get in touch with her inner experience helps her to ground and center herself, to integrate external behavior with inner feelings and beliefs. Helping the client to learn mindfulness, focusing internally, turning her attention to present experience, and to observing this experience nonjudgmentally without interference is helping her discover the very roots of who she is (Kurtz, 1984, pp. 165-166).

Mind-body holism is also important. Hakomi works at the mind-body interface. Eating disorders are desperate emotional statements that express themselves with the body. The anorectic and the bulimic tend to value and judge themselves in terms of their bodies. An inability to tolerate any body imperfection is a core issue. There is confusion and mistrust of bodily functions (Bruch, 1973; Frazier, 1965; Garfinkel and Garner, 1982; Garner and Bemis; Goodsitt, 1977; Selvini-Palazzoli, 1978).

The frequent tendency for anorexic patients to overestimate the size of their own bodies was originally observed clinically by Bruch (1962) and since then has been well-documented (Casper, et al, 1979; Crisp and Kalucy, 1974; Freeman, et al, 1983; Garfinkel, et al, 1977; Garner, et al, 1976; Goldberg, et al, 1977; Piereloot and Houben, 1978; Slade and Russell, 1973; Strober, 1981; Strober, et al, 1979; Wingate and Christie, 1978). Despite the obvious importance to clients with eating disorders, body image and body awareness concerns are rarely explored in any of the literature on psychotherapy for eating disorders. Body perceptions, by their very nature, do not readily lend themselves to articulation.

In one promising article by Wooley and Wooley (1985, pp. 414-420), body image therapy was designed to increase movement repertoire and develop feeling symbols through imagery, movement and therapeutic art exercise. In one exercise, for example, clients were asked to envision moving inside their mother's body, then to move as their mothers did. While moving "in the mother's body" they felt more out of touch with internal cues. These techniques are experimental, fairly powerful and likely to prove an important component to the treatment of eating-disordered women. They seem compatible with and easily integrated into Hakomi techniques.

#### ADAPTING HAKOMI TO SOME PITFALLS OF EATING-DISORDER PSYCHOTHERAPY

There are several pitfalls to working with the eating-disordered population which also apply to Hakomi. In my consultation with therapists, there is often confusion and frustration. Therapy seems to be proceeding with little problem or even with great success. Early in therapy the client cancels and does not return. Understanding the typical internal process can help avoid some pitfalls.

Most therapists tend to overestimate the capacity of the eating-disordered client to use therapy. Most are fooled by the client's apparent self-sufficiency and often by her ability to deny the the seriousness of her illness (Orbach, 1985; Goodsitt, 1985). The typical therapist will need to be more directive in teaching the client how to explore her feelings and how to use therapy.

The eating-disordered woman often fears that she is basically inadequate and scorned by others. Yet her mistrust is hidden from the therapist under the facade of pleasing cooperation. Her inability to identify, much less express, her feelings makes therapy more complicated. The therapist will need to be sensitive to safety issues in a complex way. The client may not feel safe but be unable to recognize these feelings. Worse, should the therapist correctly track fear and attempt to contact it, the client may hide her confusion to avoid appearing inadequate. The combination of inability to recognize feelings and

need to appear in control can often confuse and "double bind" the therapist.

The therapist might have problems with contact statements. Often being woefully unaware of inner experience, hearing the therapist describe her experience or feelings may seem a repetition of her own mother, who always told her what she felt.

Rather than attempt to contact experience in the beginning, it may be important to teach the client to recognize experience. Rather than a contact statement such as "Annoyed, huh?" a teaching recognition statement often seems more effective. "If I were in that situation, I might be annoyed or angry, but perhaps it doesn't bother you or maybe you have some other feelings." The multiple-choice nature of this approach contacts the confusion in a nonviolent, accepting way. It lessens the need to appear competent and hide inadequacy. It lessens the chance that she will again hear her mother telling her how she feels. It gives permission to explore the possibilities and compassionately articulates a sense of separateness with the therapist.

Eating-disordered individuals are more likely than most clients to experience crippling anxiety related to uncertainty and feelings of inadequacy. Many clients seem to benefit by being forewarned of feelings of discouragement and bewilderment in the early stages. This contacts her confusion and need for direction. During the first session, it is helpful to anticipate verbally that the client does not feel comfortable with psychotherapy and may wish to run from it. It is helpful to let the client know that this is common and, when this happens, you encourage her to bring this important feeling in (Goodsitt, 1985).

Eating disordered individuals frequently fear negative feelings and experience them as calamitous. There is an underlying fear that the therapist will withdraw from the client and that exposing these feelings will produce the same kind of response it did in parents. Frequently, an eating-disordered client fears that in sharing and talking she will lose what little control she has managed to create for herself. Sharing can be experienced as a

loss rather than a relief. The expression of sudden emotion can be quite overwhelming.

Especially when strong or negative emotions are expressed, it seems important that the therapist anticipate that the client may now or later feel overwhelmed and articulate this to the client (Hall, 1985). While the client is under duress, I find it helpful to make it clear you want to help her feel better about herself (Goodsitt, 1985).

It is important to be flexible about the finishing time. Especially with eating-disordered individuals, it can be devastating to begin to express feelings, particularly negative ones, only to be curtailed by an abrupt ending. Unfinished business should be clearly acknowledged at the end and brought up by the therapist at the start of the next session. How the client feels, how the week went, whether or not the client wishes to bring up any issue from the last session can be structured early in each session.

I've also found it helpful to leave sufficient time near the end of the session to talk about the experience of this session--how it met expectations and fears. It is important to encourage the client to express feelings rather than go away with them; otherwise fears and feelings of inadequacy may become sufficiently powerful for her to dread returning (Hall, 1985).

I am currently exploring working with the child with eating-disordered clients. I would like to share a technique that involves storytelling as a probe. In this transcript segment, the client is in either a child or dual state of consciousness. The therapist is telling a story when the client's body becomes visibly rigid; her expression suggests she is upset. This transcript suggests some ways to handle safely issues when inner awareness is very limited.

T: Your shoulders seem all stiff when I talk about the little girl going into the forest.

C: (lightly, seeming to disregard the intensity of her reaction) I was wondering

what's going to happen. (less into a child consciousness)

T: You're wondering what comes next. I'm curious if something in the story might be upsetting you.

C: (no verbal response, expression difficult to track)

T: (not allowing too long an uncomfortable silence) Perhaps you are scared for the little girl in the story. Maybe you found the dark forest upsetting or perhaps there's some other feeling.

C: (efforting, uncomfortable)

T: (again, brief period of silence) It's not clear.

C: (nods)

T: (still talking softly to the child) I want to try my best to help you feel safe, so I'd like to try a game. Is that okay?

C: (nods, seems back to child state)

T: I'd like to try having the little girl have a magic protector. We can decide what kind.

(Client and therapist come up with just the right kind of magic protector.)

T: I'm going to go back to where we left off with the story and have the little girl meet the magic protector, and we'll see if something interesting happens. We'll see if that changes anything in your shoulders. Maybe they'll get less tense or more tense or maybe they'll stay the same. I'll watch so I can learn some things about you and how you feel about this story. And I'll tell you what I learn while you enjoy the story.

(Therapist tracks and stitches bodily responses to incidents in the story, especially when client seems to be frightened.)

Although it takes time to build the rapport to begin "working with the child," this has been the most promising intervention

for me. Perhaps this approach addresses developmental lags in teaching about feeling safe, feeling fearful, and the way they manifest in the body. In my experience, intellectual explanations about safety seem to fall on deaf ears. This approach seems to slowly teach internal awareness that eventually prepares the client for deeper work (perhaps work with body image). Progress may be quite slow and erratic. The therapist will need much patience and ability to back off, but I find that this teaching of internal awareness and the importance of safety is often the central issue which touches all other core issues.

#### SUMMARY

Hakomi has an important place for the intrapsychic component of treatment for many individuals with eating disorders. The context for Hakomi is best seen in a perspective that includes prior evaluation important in treatment that is necessarily multidimensional. The evaluation addresses medical complications, diagnostic implications, and possible presence of endogenous depression which seems to warrant evaluation for trial on antidepressant medication. Suicide risk and need for psychoeducational intervention should also be evaluated.

Contacting the experience of an eating-disordered client may require some knowledge of her "typical" internal experience. Many clients have little inner awareness, feel terribly inadequate, but maintain a facade of pleasing compliance. An eating-disordered client generally responds best to the therapist who anticipates her discomfort and need to be in control and helps her by structuring the psychotherapy session.

I believe Hakomi has a unique ability to address the profound cultural lacks that create eating disorders in the first place. The application of Hakomi principles and techniques to the treatment of eating disorders seems best described in a separate paper. This is an evolving project for me. I am grateful for the communications of other therapists who have used Hakomi in the treatment of eating disordered individuals.<sup>4</sup> I welcome communications in the future and am glad to share what I know.<sup>5</sup>

It is not unusual to find a woman recovered from an eating disorder more alive and developed as a person than had she never developed the eating disorder. With all the complexities and challenges of treatment, recovery can truly be watching the birth of a person.

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1. Because bulimia and anorexia nervosa occur primarily among women, such clients are referred to as female throughout this article.

2. I believe this paper deserves some comment on the organization of experience. This is necessarily the organization of a psychotherapist that includes Hakomi within the rubric of clinical psychology. I realize a paper may be written that does the reverse.

3. Reprints of the article, "Medical Evaluation and Management of Patients with Anorexia Nervosa and Related Eating Disorders," are available through James C. Sheinin, M.D., Division of Endocrinology and Metabolism, Dept. of Medicine, Michael Reese Hospital and Medical Center, University of Chicago, Pritzker School of Medicine.

4. Ron Kurtz had shared a technique of taking over critical voices which seems quite useful (5/85, personal communication) and best described in Part II of this article.

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