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Eating Disorders Treatment:
An Integrative Model by Means of Narrative Counseling, Motivational Interviewing, and Traditional Approaches

Moria Golan

Shahaf, Community Services for the Management of Weight-Related Problems,
Tel Hai Academic College and School of Nutritional Sciences, Hebrew University,
Israel

1. Introduction

The devastating effect of eating disorders on health has led to their inclusion among the priority mental illnesses for children and adolescents identified by the World Health Organization (World Health Organization [WHO], 2005). Crude mortality rates for anorexia nervosa have ranged from 0 to 8% across studies, with a cumulative mortality rate of 2.8% (9 deaths for 318 patients followed an average of 11 years) (Keel & Brown, 2010). The overall mortality rate for anorexia nervosa is five times that of the same aged population in general, the highest of all psychiatric illnesses. Death from natural causes, such as cardiac arrhythmia and infection, is four times greater, and death from unnatural causes, such as suicide, eleven times greater than expected. Risk of successful suicide is particularly high: thirty-two times that in the same aged general population (Centre for Excellence in Eating Disorders, Facts and Figures, 2005). About 50% of anorexia nervosa patients/victims return to a normal body weight within six months of treatment. 25% maintain a low but stable weight, and the remaining 25% remain chronically ill or die (CEED, 2005). 76% of patients enrolled in a randomized controlled trial achieved remission by five-year follow-up (Keel & Brown, 2010).

The mortality rate for bulimia nervosa is estimated to be 0.4 (Keel & Brown, 2010). Close to 45% of the patients on average showed full recovery from bulimia nervosa, while 27% on average improved considerably, and nearly 23% on average had a chronic, protracted course. Crossover to another eating disorder at the follow-up evaluation in 23 studies amounted to a mean of 22.5% (Steinhousen & Weber, 2009). As with studies of anorexia nervosa, remission rates for follow-up studies of bulimia nervosa are lowest for those with the shortest duration of follow-up (27–28% at 1-year follow-up) and increase as duration of follow-up increases (up to 70% or more by 10-year follow-up) (Keel & Brown, 2010).

1.1 The unmet challenges reflected by eating disorders

Clearly, many people live with an eating disorder for many years, particularly those who purge. They come to terms with it because symptoms are perceived as being preferable to the alternative distresses, as explained by different theories.

1.1.1 "Self" theorists

"Self" theorists argue that patients with anorexia nervosa and bulimia nervosa cannot rely on human beings to fulfill their self-object needs. In Kohutian terms, they cannot expect that others will give up, even temporarily, their own interests and viewpoint for the sake of fulfilling their self-needs, such as regulation of self-esteem, calming, soothing, and vitalizing (Kohut, 1977). Instead, these patients rely on a substance, food (its consumption or avoidance), to fulfill these needs. Therapy progresses when the patient gives up the pathological preference for food as a self-object and begins to rely on human beings as self-objects, starting with the therapist. According to this theory, eating disorder patients feel and behave like selfless souls serving others' needs. Women with anorexia nervosa are liable to feel self-guilt whenever they find themselves promoting their own interests (Goodsit, 1977). Bulimic symptoms may be utilized, for example, to soothe painful and unacceptable feelings or to adapt to an environment in which the self is constantly subjected to painful and/or damaging experiences. Strober (1991) suggests that a genetically-based personality style of high stimulus-avoidance, low novelty seeking, and high reward dependence, rather than restrictive parental behaviors alone, inhibits the natural exploration necessary for normal self-development. Vitousek and Ewald (1993) suggest that both genetic and environmental factors contribute to the failure to develop a clear and stable set of positive selves, leading to an over-reliance on environmental cues to define the self and to feel noticed.

1.1.2 Ego theorists

Ego theorists argue that eating disorders serve as defense against reality. Bruch (1982) emphasizes ego weakness and interpersonal factors. Her basic theory is that anorexia nervosa is a struggle for self-respecting identity in the context of autonomy-inhibiting parents; it is the failures and impairments in ego development and functioning that are of particular interest. These include an arrested conceptual development, a nearly delusional disturbance in body image, which is symptomatic of a much wider misperception, and a striking sense of ineffectiveness. In extreme cases it is a mechanism to avoid any genuine connection with reality or any representation of reality and the fears and anxiety associated with it (Bion, 1959). Resisting treatment is actually a considerable investment in the patient's need to maintain control over his/her internal and external worlds and the objects within them (Williams, 1997), a way to remain immature, with no responsibilities, narrow views, and protection from life's demands.

1.1.3 Developmental theorists

Developmental theorists assert that during times of emotional turmoil and disturbing life circumstances, eating disorder symptoms reflect a defense against developmental challenges. Bruch (1982) proposes that the adolescent turns to body weight as a viable source of self-definition and as an arena in which to struggle for autonomy, competence, control, and self-respect. Bruch (1982) sees anorexia nervosa as developmental defect: as the girls grew older, they found that to continue to be well-behaved by their parents' standards, they had to remain little girls, both physically and psychically. Thus they found in stringent dieting a process that accomplished two important goals: it kept them little and gave them one thing over which they had sole control. When the girls reach menarche and should

begin dating boys, they retract into a cage, and, by losing weight, pull themselves back from the brink of adulthood. Menstruation stops, if it had begun, and they throw themselves into physically demanding activities, usually athletics, which garner them much praise and admiration and provide a convenient excuse for avoiding boys. An ingenious solution, one that the perpetrators are usually surprised to find is not unique to themselves. Crisp (1980) views anorexia nervosa as a mechanism by which the patient regresses to a pre-pubertal shape, hormonal status, and experience to avoid the fears and conflicts associated with psychosexual maturing. Eating disorder symptoms—restricting, purging, compulsively overeating, always feeling fat—provide distraction from original sources of personal stress or key developmental tasks in adolescents (Bruch, 1982). The thinking imposed by eating disorders directs the mind to criticize the body, obsess about food, and draw attention to weight loss. rather than to explore distressing feelings. Thus the eating disorder is less about food and weight than about trying to "solve" one's problems in life. In some cases, for example, an eating disorder may serve as an excuse for social difficulties and as a means of escaping psychosocial pressures; in others it may serve to unite parents in a troubled marriage and as a means of getting "special treatment" because the child could not recognize or express his/her primary distress.

1.1.4 Regulation theorists

Regulation theorists claim that by refocusing one's attention onto weight, shape, and eating, one gains a sense of emotional control and a sense of accomplishment. People with bulimia nervosa attempt to elevate their mood by eating; purging allows them to avoid gaining weight. Unfortunately, the person with bulimia nervosa eventually realizes that the binges are out of control and begins to feel guilty and to dread eating. Eating no longer provides relief, but rather, induces negative emotions such as guilt. Purging may then relieve the guilt, as well as discharging anger. It is thus possible that purging eventually replaces bingeing as a means of tension reduction (Polivy & Herman, 2002). In fact, bulimia nervosa patients report reduced anxiety and depression following a binge/purge episode (Sanftner & Crowther, 1998; Steinberg & Shaw, 1997). Bulimic behavior has been proposed to result from unregulated affects. The anorexia nervosa patient achieves at least partial emotional gratification by avoiding food and achieving slimness. More recent theorists concur that an extreme need to control both eating and other aspects of behavior is a central feature of eating disorders (Fairburn et al., 1999). Gaining a sense of control and pride in one's ability to control one's eating combats the feeling of being taken over by thoughts of food or of lacking control of one's thoughts, eating, and weight (Serpell et al., 1999).

1.1.5 Social perspectives

Social perspectives identify the idealization of slimness and the societal disparagement of overweight as major contributing factors to women's weight and shape dissatisfaction and related self-disgust (Striegel-Moore, 1997).

Feminist researchers argue that the "eating disorder" is a reflection of young girls' unease with social roles approved in Western, patriarchal societies, where gender inequality still prevails. Disease creation, therefore, becomes a way of gender control (Malson, 1999). This interpretation is derived from Foucault's power philosophy (Foucault, 1988) and our understanding of AN as a disciplinary practice that medicalizes the body and is interpreted

through interrelationships between knowledge, social practices, and institutional authority (Hepworth, 1999).

1.1.6 Family theorists

Family theorists discuss three main areas in relation to the etiology of eating disorders: the family system and its organization, the patient's entanglement in his/her parents' conflict, and control issues in the family. Family theories have been implicated not only in the maintenance of eating disorders but also in their development (Minuchin et al., 1978). Minuchin, from his family interaction perspective, stresses the self-sacrifice, loyalty, and protectiveness of patients with anorexia nervosa towards their parents ,[22] the same motives reviewed above from a self-psychological and cognitive sociological perspective. Minuchin furthermore emphasizes guilt as the underlying motivation for this self-sacrifice in the service of the family's needs. Ward et al. (2000), however, conclude that "many of these (family dysfunction) characteristics are regarded as secondary to the presence of an ill family member, rather than causative." Perhaps problems of identity and/or control are central to eating disorders, with the individual attempting to resolve these problems by investing emotionally and behaviorally in the pursuit of slimness. The family, of course, may contribute directly to problems of identity or control and may also suggest the solution, by emphasizing slimness as a panacea. Steiger et al. (1996) conclude that families (including so-called normal families) may transmit eating concerns, but without an additional vulnerability factor, family factors do not explain the emergence of an eating disorder.

1.2 What type of therapy may address these challenges?

The best outcomes are achieved with those whose condition is identified early and who receive appropriate treatment. The National Institute of Clinical Excellence (NICE) guidelines (2004) recommend that people with eating disorders should first be offered outpatient treatment and that inpatient care be used for those who do not respond or who present with high risk and few support resources. Day treatment plans provide an intermediate treatment model. Practice recommendations emphasize the importance of specialized care for the treatment of eating disorders (American Psychiatric Association [APA], 2006).

There has been extensive research on different types of therapeutic approaches to the treatment of eating disorders (APA, 2006). Practice recommendations emphasize the importance of specialized care for the treatment of eating disorders, but such care is not often accessible (APA, 2006). Moreover, as Treasure et al. point out, comorbidity for patients with eating disorders is the rule rather than the exception (Treasure et al., 2010). Interest is growing in a transdiagnostic approach to eating disorders, both within and outside the field of eating disorders, with suggestions they should be linked to the obsessive-compulsive and autistic spectrums or to anxiety and mood disorders. An intervention model that approaches illnesses from a transdiagnostic orientation, which addresses the dynamics and needs of comorbidities while treating the eating disorder effectively, has been proposed.

Pluralism, consumerism, mobility, and increasing access to news, entertainment, and other features of the post-modern world have brought multiple therapeutic approaches, as well. In specialized eating disorders units, we see patients who receive nutrition counseling and

pharmacotherapy alongside interpersonal psychotherapy (IPT), cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), psychodynamic therapies (PT), and family-based therapy (Maudsley), as well as motivational enhancement interviewing (MEI or MI) and even elements of narrative therapy delivered by 2-6 team members. The difference among programs lies mainly in the management or the spirit of the therapeutic environment created by the strategies and practices of the team members and the manager. Post-modern approaches such as narrative therapy and MI (motivational interviewing) encounter the traditional medical model, which imposes authority and discipline.

1.2.1 Narrative therapy

Narrative therapy was developed by Michael White and David Epston (White & Epston, 1989). Incorporating the gender power analysis of feminism, narrative therapy was significantly influenced by Michel Foucault (Foucault, 1988) and his analysis of power (White & Epston, 1989). Narrative therapy challenges the idea that expert knowledge belongs to the world of therapists and the medical model. It challenges the truths and alleged objectivity of these disciplines, instead taking up the ethic of collaboration and engaging in the practice of "co-research" (Epston, 1991, 2001). It explores factors that have contributed to the meanings the person has constructed about his/her life and experiences and identifies the person's knowledge about the influence of his/her eating disorder on his/her life. It also identifies knowledge about factors supporting or undermining that influence. The counselor explores unique ways in which eating disorder patients resist and challenge problematic behaviors we call "pro-eating disorders steps," such as eating less or deciding not to join friends because of eating or mood issues (Lock, et al., 2005).

 In contrast, decisions such as eating regularly, are called "anti-eating disorders steps" or "unique outcomes," which are viewed as foundations and possibilities for further change. Maisel, Epston, and Borden (2005) posit that people experiencing eating disorders have accumulated "insider" knowledge about living with the eating disorder that is different from others, such as therapists, who do not have that experience. Michael White incorporates some of the ideas of Lev Vygotsky and his proposals on ways humans might be assisted to move in new directions in collaboration and through language. White explains the practice of scaffolding conversations using Vygotsky's ideas (White, 2007). He uses Vygotsky's idea of "the space moved through" to obtain a new outcome, the "Zone of Proximal Development." White claims that crossing this zone takes a person from what is known and familiar (but perhaps not useful) towards "what it is possible to know and do." The art of re-authoring conversations, which is the practice of narrative therapy, invigorates people's efforts to understand what is happening in their lives, what has happened, how, and what it all means. In this way, these conversations encourage a dramatic re-engagement with life and with history and provide options for people to inhabit their lives and their relationships more fully (White, 2005). Co-research is considered an important method in narrative therapy.

1.2.2 Motivational interviewing

Motivational Interviewing is a directive, patient-centered counseling style for eliciting behavior change by helping patients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and

resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal. Rollnick et al. (2008) called the communication style often found in helpful counseling "guiding style." The guiding style involves an approach in which a patient and counselor work as a team. They "walk" together, but the practitioner points out routes and options, serving as a resource about what is possible, what others have done, and what the risks and benefits might be of each approach. By pointing out possible paths, the practitioner helps the patient to choose directions that best suit him or her (Rosenberg, 2009). In this style the implicit message is, "I'll help you solve this yourself." Motivational interviewing uses reflective listening in guiding the person to resolve ambivalence about behavior change (Rollnick et al., 2008).

Narrative and motivational counseling share reliance on patients' personal agency rather than on a relationship of power. This encourages collaboration, evocation, and autonomy, empowers people, and strives to help them avoid eating disorders and other dangerous behaviors.

To avoid blaming, narrative counseling uses externalization, a process of creating a linguistic space or a sense of separation between the person and the problem by engaging in conversations that position the self in relationship to thoughts, feelings, experience, and actions (White & Epston, 1989). Over time people with eating disorders come to believe that the disorder is part of their identity. Externalizing conversations begin a process of deconstructing the beliefs and ideas that fuel the problem, examining where these discourses are situated and how they exert an influence on the person's life, "deconstructing some of the 'truths' that persons have about their lives" (White, 1995). They create a linguistic and experiential space for the person to view the problem and his/her relationship with it from a different perspective (Madigan & Goldner, 1998). Instead of being immersed in the problem, "a person gains a reflexive perspective on their life, and new options become available to them in challenging the 'truths' that they experience as specifying them and their relationships" (White & Epston, 1989).

In a different way but with the same intentions, in motivational interviewing the therapist aims to avoid conflict, resist a righteous stance, and understand patients' motivation even if s/he does not agree with the resulting behavior. Motivational interviewing makes use of OARS (open ended questions, affirmations, reflections, and summarizing) to "dance" with ambivalence rather than confront patients.

Furthermore, both approaches focus on change. In motivational interviewing, enhancing self-change talk is a core component. The counselor strategically elicits change talk and consistently responds to it when offered. In narrative therapy, a counselor usually asks, "Where does this knowledge take you? In what way will you respond differently now that you have this knowledge?"

Both narrative and motivational interviewing counseling have been adopted in a variety of health care areas. The idea of "marrying" narrative counseling and motivation interviewing in the treatment of eating disorders is not unique to our model (Leichner, 2005). Leichner described a comprehensive eating disorders program delivered at British Columbia's Children's Hospital using Motivational Enhancement Interviewing (2005). This model is in essence a repackaging of several different therapeutic approaches based on the stages of change model developed by Prochaska and DiClemente (1986). It includes components of

cognitive behavioral therapy, psycho-education, patient-centered therapy, and narrative therapy. The author emphasizes that active listening and other strategies have replaced the more coercive and confrontational methods used in the past to treat AN and related disorders. The effectiveness of integrating various therapies and approaches in the management of eating disorders is not surprising, as survey findings consistently show that clinicians tend to identify less with any one approach the longer they have been in the field. Experienced therapists tend to pick and choose from a variety of approaches in an effort to tailor treatment to the makeup and characteristics of the individual patient (Duncan et al., 1999). This is certainly appropriate for transdiagnostic comorbidities. Duncan et al. (1999) show that the patient's view of the presenting complaint, potential solutions, and ideas about the change process form a theory of change that can be used as the basis for determining "which approach, by whom, would be the most effective for this person, with that specific problem, under this particular set of circumstances."

The current manuscript is innovative because it presents a model that goes beyond Prochaska and Di Clemente's process of change model (Prochaska & DiClemente, 1986). It was first developed for parents who expressed their longing for an anchor, a sense of control and location, while battling their daughter's eating disorder. For them, we defined five phases along the journey to recovery as a guide map. We are aware of the risk of simplification of a most often complex reality when establishing therapeutic models due to the desire for certainty and comfort, as well as the risk of falling into the trap of "knowing." We are also aware of the spiral, as opposed to linear, nature of the change process.

2. Treatment program and principles

Shahaf is a community-based facility for the treatment of eating disorders in Israel that provides various level of treatment intensity. We work with the whole spectrum of weight-related problems including severe food restriction for weight loss, excessive exercise, and purging behaviors such as vomiting, binge eating, and chewing and spitting. Approximately fifty patients are in treatment at any one time.

Comorbidities such as depression, obsessive compulsive disorder, and self-injuring behaviors are very common among our patients, who are often self-disparaging, convinced life has no value, pessimistic about the future, and unable to initiate or experience enjoyment. All admissions are voluntary. Treatment plans are tailored to the needs of patients and their families, and treatment is delivered by a multidisciplinary team.

Since we view emotional dysregulation as the core problem in eating disorders, each patient is allocated to at least one type of therapy aimed at improving his/her regulation skills and enhancing change in emotional states (psychotherapy, art therapy, drama therapy, and biofeedback). Skills for regulating emotions are acquired in most psychotherapies. "Meaning making" as acceptance and change, active validating of the worth of the individual, and mindfulness skills to substitute sensual activities for food satiety are included in therapy. Parents are invited to participate in a psycho-educational support group where they receive information and emotional support from the group facilitators and other parents who share experiences and offer possible solutions. Nutrition counseling, family therapy, and other components of psychiatric management

for patients with eating disorders are also important: the therapeutic alliance, coordinate care and collaboration with other clinicians, assessment and monitoring of symptoms and behaviors, and cognitive and behavioral techniques such as stimulus control procedures and strategies aimed at modifying rigid all-or-nothing thinking and perfectionism, are also central in this program.

In addition, during the course of an intensive treatment, 5% of patients receive between six to twelve hours per week of contact with clinical mentors. Clinical mentors are social workers, clinical dietician, and graduate level psychology students who are trained to connect with patients in an intensive, informal manner. Senior clinical psychologists supervise them once a week, individually and in a group. The mentors address the need for a holding and containing environment, as well as the presence of a strong and reliable emotional resource, countering the eating disorder voice and helping the patient voice his/her own values. They serve as meal companions and soothing figures, representing a healthy self-caring image, which counters maladapted patterns of interaction, cognition, and behaviors. Social skills training as well as leisure-time activities are encouraged. Further along in the recovery process, patients are encouraged to direct their hunger for relationships away from the mentors to new friendships.

In order to counter the patient's resistance to change and the power struggle that often occurs when treating eating disorders, the narrative language (White & Epston, 1989) is utilized toward treating symptoms. During narrative conversations, AN and BN are externalized, and people are encouraged to identify the ways in which the eating disorder has taken over their lives (e.g., via isolation, physical and emotional disappearance, engagement in self-policing, empty promises, etc.). The therapists then enlist patients to form a coalition against the illness to regain freedom, engaging in change rather than guilt or blame, which are often the dominant feelings among patients with eating disorders (Grieves, 1997). Treatment integrates narrative therapy, motivational intervening, dialectic behavior therapy, cognitive-behavioral therapy, bio–feedback, and dynamic approaches. Psychosocial interventions are chosen on the basis of a comprehensive evaluation of the individual patient, considering cognitive and psychological development, psychodynamic issues, cognitive style, comorbid psychopathology, patient preferences, and family situation. Thus, different pathologies receive different treatment strategies, but the conversation is always a collaborative, generative process mutually constructed between the therapist and the people seeking help.

3. The process of the journey from patient's denial to recovery

Below is a description of a five-phase process to facilitate recovery. The therapeutic relationship as well as the practices engaged in will be described, from the first meeting, through the formation of a strong joint coalition against the problem, and to the farewell.

3.1 Preliminary phase: Choosing a shelter of understanding

Preliminary Conversation: collaborative authoring the patient's entanglement in the disease network. During this phase the patient and his/her parents assess and choose the site of therapy. They look for a shelter of understanding, a place where they can trust the

professional's expertise as well as attitude towards patients with respect to autonomy and hierarchy.

3.1.1 The first "intake" conversation

The first "intake" conversation is performed with the clinical director (Prof. Golan) and the patient, and later on the parents join for a second re-telling of the patient's story. This session is aimed at get to know the patient, his/her problem, and how the problem took over the person's life. During this first "intake" meeting, open-ended questions are used to explore the story of the patient's childhood, what kind of a child s/he was, and what characterized her/his friendships. A major thrust is to explore unfolding hints that the eating disorder might have taken advantage of and given an illusionary protection: regulatory issues, fears, desires, self-control issues, social difficulties, personality traits, family conflicts, and the presence of a defensive style (tendency to deny or avoid conflicts). We might reflect that the eating disorder symptoms (preoccupation, slimness) may be helping the youth to deflect other distresses.

In this session, externalizing conversation is used to position the illness outside the patient and to contradict most patients' perception that they are the problem, that there is a deficit or defect of some kind within them or within their family dynamics. When they are labeled "anorexics" or "bulimics," linguistics promotes the full assimilation of the eating disorder into their identity.

In narrative terms, the person is referred to as being totalized (Maisel et al., 2005) by the effects of the eating disorder. Self-blame and guilt often arise from these perceptions. During this conversation the patient starts to understand how the eating disorder and emotional issues are related. We gently unfold the development of the signs and symptoms of the eating disorder and teach the patient to identify the traces of the eating disorder by him/herself. Some may see/understand, and some may not. Some may see and then forget. We then ask the patient's permission to invite his/her parents into the room and to share with them the story of how *we* (s/he and I) understand the problem have developed.

We re-tell the birth of a sensitive child with sensitive self-regulation (as was expressed by the events that the patient has described) and how the eating disorder took advantage of this core issue. We repeatedly re-tell the story of how the eating disorder took advantage of the patient's difficulties (based on what s/he has told me) and explain how the eating disorder distracted him/her from resolving his/her problems and provided short-term relief. We add that s/he now seems to view the price as being too high.

The patient is now asked to describe why the price has become too high for him/her and what his/her goals are. What are his/her goals/aspirations/life objectives?

The different budgets that our facility offers are presented, and with the family we consider which level of intensity is appropriate for the patient's physical condition, occupational functioning, and other factors. When a patient feels understood and can trust the treatment provider, s/he is more ready to enter a meaningful bond and consider treatment as an option.

After the parents approve the reframed history of the problem, we set the treatment goals. The main priority of the therapeutic alliance is stressed, guiding the process of recovery towards those issues that have been identified as difficult for the patient (not necessarily diagnostic symptoms) and what the patient feels should direct the goals of treatment. We insist that the patient feel as if s/he is a valid, significant part of the therapeutic alliance and has a personal role in the recovery process, decreasing the patient's feeling of being "controlled" throughout the treatment process.

Because anorexia nervosa patients tend to see their disorder as an accomplishment rather than an affliction, they are unlikely to enter treatment to free themselves from their feelings of guilt and shame, which are the motivational source of an introjected regulation. As such, we would predict that those with anorexia nervosa display a lower level of introjected motivation to change compared with other eating disorder patients.

The primary goal is to reassure patients that their apprehensions will be carefully appraised in shaping the interventions undertaken, and that changes sought will be measured against their tolerance of the anxieties that may be triggered, so that risk of terminating treatment is minimized.

This therapeutic stance, in which the therapist is viewed as a consultant helping the patient and the family, with little difference in power among them, may encourage both patient and parents to work more collaboratively, rather than deferentially. The team, thereby, increasing their ownership of treatment and outcome and strengthening the therapeutic bond.

Moreover, using a combination of narrative and motivational interviewing skills that emphasize that the patient or family holds the solution rather than the problem helps to establish effective cooperative bonds.

3.2 Phase 1: from partial recognition to full acknowledgment

During the first phase of the journey, there is only partial recognition of the problematic status. Neither parents nor patient are fully engaged in treatment and the full impact of the disease is not recognized. Patients feel stressed by their eating disorder but also safe, as if they were in a "bunker." Thus, the counseling focuses on engaging and guiding towards acknowledgment of the disease.

Although during the intake session the patient may seem to understood the relationship between the eating disorder and emotional issues, when the program starts, denial returns; the patient becomes trapped once again in the belief that the eating disorder is his/her guardian, and "sings" the familiar melody: "I am healthy, I can put on weight by myself." Parents can be firm and overcome this potential impasse by reminding the patient of the elusive nature of his/her eating disorder and stating firmly that, as previously decided, s/he will start the program. They can remind him/her that treatment is the way to achieve what s/he wants above all else: his/her autonomy. The case manager forms a general therapeutic alliance with the patient but allows several exceptions from the formal form to model active listening and mutual respect (e.g., "at the moment, X prefers not to commit to gain the target weight rather than improve the weight status").

Objectives

Objectives of this phase include the creation of a meaningful bond; comprehensive assessment (physical, nutritional, psychiatric, psychological, family dynamics, defense styles); the development of an alliance; and the beginning of physiological and emotional stabilization.

Means

Curiosity. In order to create a meaningful bond, patients must experience therapists as caring people who honor their views, feelings, ideas, and resources. For example, therapist and patient can examine how change usually happens in the patient's life, paying particular attention to the sequence of events, the role the patient and others adopt in the initiation and maintenance of change, and the success or failure of any attempts to resolve the illness and other problems.

OARS (Open ended questions, Reflections, Affirmations, Summarizing). This involves assessing nutritional status and discussion with the patient about the impact of exhaustion on different areas of his/her life. The patient may be asked what bothers him/her most— e.g., growth, autonomy.

Therapeutic alliance. We take a clear stance against the problem with firm focus on behavioral goals and announce clear boundaries and rules (stages of independence and discussion about which decisions should be mutual and which should not in each stage). Staff should clearly communicate that they are not seeking to engage in control battles and are not trying to punish patients with aversive techniques. The role of the patient in the treatment process is equally important to that of the treatment team. In this sense, the patient is an active participant and is accountable for his/her actions in the quest for behavior change and improvement in his/her quality of life**.** Patients must honestly and accurately disclose information to the individual therapist and staff. Patients should make a sincere effort to report accurate information about the history of the disorder and present symptoms, behaviors, and any past relapses. Patients must make a concerted effort to participate actively in the treatment program as well as any recommended intervention outside of the treatment setting.

We agree to support the patients' autonomy as long as s/he makes decisions that serve his/her own good and do not nurture the eating disorder. This often depends on the degree to which the patient perceives his/her locus of control within the treatment structure. If the progress of recovery is slow, a decision may be made to increase the level of care within the setting. This decision should involve the patient, the family, and/or support persons, so that they are accountable for their actions and the facilitation of recovery.

Validating environment. Elements crucial to the creation of a validating environment include recognizing the complexity of problem- solving skills, encouraging the expression and sharing of emotion, and encouraging the patient to trust his/her own emotional and cognitive responses as valid interpretations of situational and individual events. It is important to keep in mind that for any individual case, certain elements of treatment are more difficult than others.

Individualized identification of the primary "obstacles" to recovery. Acknowledging that weight gain is frightening for most patients can strengthen the therapeutic alliance and decrease the likelihood that the patient will perceive the therapist or treatment team as just wanting to make him or her "fat," versus truly understanding the emotional aspects of the recovery process.

Ongoing direct communication between the healthcare professionals and family members is of utmost importance. Families need to be kept up-to-date on the process, progress, and plans during treatment. They need to be informed directly, not just through their child, in order to avoid misinterpretation and misunderstanding. When possible, it is advisable to talk to parents with the patient present, to ensure that everyone hears the same message. Information provided to parents or by parents without the youth's knowledge leads to secrecy that can interfere with treatment. Openness and trust are best promoted by sending copies of notes or assessments to the family or sending them updates in the form of letters.

Externalizing questioning. This emphasizes the influence of the eating disorder. It includes recognizing illness tactics, illusions, and "prices" (unmasking), alongside advantages.

The patient may be asked, "Do you feel some power, some force, trying to persuade you not to eat or to binge and, if so, what? For instance, a patient may describe thoughts such as: "I want to binge. I can't control myself." We try to externalize it, to emphasize these thoughts as the property of an external voice. So we say something like, "Can you tell me more about these thoughts that came to you? What else did they say?" And s/he might reply, "It will give you relief." Then the therapist reflects, "So the eating disorder promises relief." Then s/he might ask, "Does the voice of these thoughts always sound the same? If so, how would you describe it?"

Some people find these questions easy to answer, but others do not. Nonetheless, we continue to ask questions because it is vital that we find a way to externalize and personify the voice of craving. Once we have found a resonant way of externalizing the problem, a way that fits with the person, many options open up. This is the crucial first step. Some find it easier to invite the patient to draw the problem and then reflect on their drawing: "It's a confusing image if she seems a witch with a magic wand and at the same time a guardian who keeps you from harming yourself; no wonder you are ambivalent about her presence." After s/he has talked a bit more about his/her experience of the problem and the way it impacts him/her, and about the patient's voice and thoughts that influence decisions and behaviors, we try to come up with an experience-near definition of the problem.

The aims of this means are to recognize illness tactics and illusions; gain familiarity with the eating disorder characteristics; express curiosity about how life might be without the eating disorder; engage the patient or help him/her become aware of the impact of current physical status and eating habits on his/her social relationships. Questions that the therapist may ask a patient include: How does the eating disorder get the you to think about it more than you wants to? Other people told me that the eating disorder got them to believe that they are not in danger when in fact they are; is it the same in your case? Other people told me that the eating disorder caused them to be dishonest with themselves; how about you? From which of your values does your eating disorder attempt to separate you?

Generally, it is not difficult for people to describe the feelings they experience and how it operates or what tactics it uses to influence their thinking (frightening, exaggerating, totalizing). We then ask a series of questions to gain more information about the timing/context of these thoughts: When do these thoughts come to you most, in what situation?

Seeing how the eating disorder is interfering with life. We talk about all the different effects the problem is having on the patient's health, friendships, hopes, and dreams. We also talk about the eating disorder's strategies and tactics. Some of these can be very tricky. By exploring these in detail it becomes easier for the patient to become more alert and sensitive to the ruses and technologies of craving. Conversations address the connections between the patient's temper, perceptions, difficulties in self-regulation and self-control, and deficits in social skills or learning, and how being preoccupied with the eating disorder distracted and relieved the patient from these things.

Having discussed the tactics and effects of the craving, the person is then asked to evaluate these effects. In both motivational interviewing and narrative therapy, we seek to develop a distinction between the patient's current maladaptive state and a more adaptive alternative. This might be done in various ways:

A "decision matrix" of the relative pros and cons of either changing or accepting their status quo. Practitioners might share their concern and at the same time recognize the patient's reasons and fears associated with change. This functional analysis of the pros and cons of a belief or behavior has become part of cognitive behavioral therapy for bulimia nervosa (Wilson, 1997) and has been incorporated in the treatment of anorexia nervosa (Bruch, 1982).

Cognitive therapy technique to facilitate change using the Socratic method to help patients think through the advantages and disadvantages of a particular belief or behavior (Overholser, 1993).

Motivational interviewing: Discuss discrepancy between current behavior and values in life: "How does the eating disorder distance you from the value of honesty, which you emphasized is very important to you?"

Narrative practice: "How would you describe your relationship with the problem? Is it positive or negative relationship? Can you name this relationship?"

Both motivational interviewing and the narrative approach are progress-oriented, and the therapist is always expected to ask, "Where will this knowledge take you?" This is the guiding style; change and growth must be supported by directing patients to think of a more adaptive alternative to their difficulties.

3.3 Phase 2: from acknowledgment to clear cognitive stance against the eating disorder – the turning point

When patients acknowledge that their life was totalized by the eating disorder, they know they should fight it. Still, knowing is not enough to overcome what is inconvenient and even painful. At this stage they progress due to their trusted figures (parents and therapists), like children who learn things not because they internalize the values, but because they internalize trust – the idea that the adults want their best.

Patients perceive the illness as harmful but at the same time as a necessary defense strategy against fatness. During this period they will eventually feel by themselves the incentives of feeling satiety and security, as well as the incentives of direct communication rather than acting out, and hopefully develop a sense of hostility towards the eating disorder.

Objectives

The objectives of this phase include: progress in physiological stabilization; strengthening of the patient's stance against the illness; symptomatic improvement; facilitation of more anti-eating disorder steps; generation of a broad description of unique outcome, skills, and knowledge about the patient as a person (knowledge, skills, identity); and development of an alternative/preferred story about the patient's coping skills.

Means

At this stage, in all treatment areas, we focus on mapping out anti- and pro-anorexia/bulimia nervosa thinking and behaviors in the different domains (food, social, personal, family) and explore how the person is influencing the problem. In family therapy we recognize familial dynamics that enabled the eating disorder to set in. These include the influence of culture, ethnicity, discourses, sensitivity, guilt, secrets, strangeness, splits, power relations, family structure, family communication, and values important to the family.

Expanding the patient's influence on the problem using reflection and amplification of unique outcomes (White, 2005). Unique outcomes are exceptions to the problem, events in which the patient's behavior cannot be predicted by the problem. In narrative counseling we use a range of questions that focus on exploring the patient's experiences during the last week of successfully avoiding or resisting pro-eating disorder temptation/steps such as craving, binging, vomiting, over exercising, and skipping meals. We invite the patient to describe in detail any situation in which s/he has been able to avoid, postpone, or resist such temptations: When was this? Where was s/he? Was s/he alone or with friends? Gradually, a picture of the situation emerges, and we ask further questions: What did you do at this time? What were you saying to yourself at the time? What were you saying to the temptation? In response s/he might say, "I was trying to watch a movie," *or* "I and had a long conversation with a friend, and this helped me forget or ignore the temptation."

We try to generate a broad description of the skills and knowledge that they were drawing on at the time. From the viewpoint of motivational interviewing, this process serves as affirmation. Once we have generated a rich description of one particular time they resisted the temptation, we then ask if they had any similar experiences. We try to recall other times they used similar strategies. The process gradually becomes easier.

Identity formation. We then ask what these stories of successful events tell the patient about him/herself as a person. In asking this sort of question we seek a name for an alternative plot, an alternative narrative about the patient's life and identity. Perhaps the patient might say, "Well, I am thinking that maybe I am not as hopeless as I first thought. Maybe I do not give in all the time, maybe I am quite determined… I am not sure about this… I had not thought about it in this way before this conversation… but yes, maybe I am kind of

determined." The patient often expresses surprise at this point. S/he is used to understanding him/herself only in negative terms, but by slowly and carefully eliciting particular skills and knowledge that the patient has used to resist the craving, different conclusions about his/her identity become possible.

In order to develop it further, I invite the patient to give a name to this alternative story that describes his/her agency, even if limited at the moment. This storyline may be named a story of "overcoming" or "determination" or "not giving up." Once we have a name, we might ask, "What has made these acts of relinquishment possible? Do you have any past experiences that may have cultivated them? We seek some historical evidence to support the new story, and this part of the process is not so difficult. In narrative practice we call this process the art of re-authoring the alternative or preferred story. As it develops we might also ask, "How will this trait, or this ability to resist the problem, help you in the future?" We try to imagine how they can use the skills and qualities that we are describing to resist their current difficulties. These questions can be asked again and again.

Cognitive behavioral therapy skills. At this stage, some team members might use cognitive behavioral therapy tools in conjunction with narrative practices to develop alternative ways of obtaining a good physical feeling, enhancing performance, increasing the variety of food items, eating with friends, and reducing obsessive compulsive symptoms. OARS and eliciting change talks are used to support the patient's self-efficacy in these phases of the journey. The same process is conducted with the family. The unique outcome, when the family was not tempted by the eating disorder traps and adopted alternative dynamics, is explored.

3.4 Phase 3: against the "patient" status – delayed adolescence and rehabilitation phase

During this phase of the journey, patients acknowledge the incentives of satiety and understand that as long as they eat regular meals and take care of their physical health, they can concentrate, feel better, and sense the ability to have a normal social life. They still do not believe in their ego strength and their ability to be like other people and face the challenges of day-to-day life. Counseling focuses on enhancing self-efficacy and supporting patients' independence. This phase lasts as long as it takes the body and psyche take to "catch up" to the developmental stage of body and mind before the eating disorder began. It might be seen as delayed adolescence.

Objectives

The objectives of this phase include: increase in independence; improvement in self-regulation and self-control; improvement in coping skills; and improvement in social and occupational functioning.

Means

Motivational interviewing principles lie at the core of this phase, as patients fear the challenges of life. Resisting a righteous stance, expressing empathy, and communicating acceptance are the most important attitudes during this phase of the journey.

We Use a decisional balance sheet and develop a distinction between the patient's "ill status" and the possibility of being recovered (Miller & Rollnick, 2002). We occasionally use a series of "miracle questions" drawn from solution-focused therapy (Walter et al., 1992).

Elaboration questions are used to explore the patient's importance, confidence, and ability to move beyond the "sick" status using the staging rulers. Acknowledging, eliciting, responding, and summarizing change talk are all frequently used.

Conversations focus mainly on what works and monitoring progress in self-regulation, self-control, and coping skills. Self-identity, values, wishes, events, and other developmental steps achieved during the struggle against the illness are recognized. This is done mainly by paying attention to unique outcomes according to narrative practice, naming preferred stories of rebellion against the dictator of eating disorders and re-authoring the story of the individual identity according to what is explored in each session. In terms of MI practice, we use a guiding style to engage with patients, clarify their strengths and aspirations, evoke their own motivations for change, and promote autonomy of decision-making. When guiding conversations about identity and values, we continuously question how our cultural beliefs are shaping our assumptions about what sort of lives people ought to be living, in order to avoid imposing our values.

External witness interviewing. To affirm and amplify the patient's achievements, we engage in another narrative practice called outside witness interviewing. We engage in this practice once every three months with each patient and use it as a follow-up session with the parents. In this particular narrative practice the first author invites the patient and the parents to a follow-up session focusing on the change process. The setting, which includes three interviews, is explained: The first is between the patient and me, with parents serving as external witnesses (only listening). Then I interview the parents, and the patient serves as outside listener. Then we have a discussion that includes a letter from all therapists. Finally, I interview the patient, asking how s/he would like to name the current journey in the program and what the journey means to him/her. OARS are used throughout this 15-minute conversation. Then I interview the parents, who were instructed not to criticize or evaluate what they have just heard, but simply to pick a phrase or image that stood out for them. They are asked to associate this item with their personal life and values. Then they are asked to reflect how their parenting has contributed to the patient's achievements. We then read aloud what the therapists wrote about the journey the patient and his/her family have made as they see it, and what still remains to be done. I leave space for all participants to respond to what has been written and to fix the agenda for the next three months.

3.5 Phase 4: re-authoring life – regaining self-agency

When the whole person catches up on the process of true maturity, the individual resumes cooperativeness, self-directedness, and self-transcendence, which allow identity to integrate fully and thrive. In this phase of the journey it seems that the patient can live without symptoms but would rather not declare this yet. Treatment intensity is gradually reduced and counseling focuses on empowering the patient and outsider witness practices.

Objectives

The objectives of this phase include: normalization of weight and eating behavior; improvement in obsessive compulsive disorder behaviors; acknowledgment of self-regulation and self-control; normalization of social and occupational functioning.

Means

Narrative practice – Statement of position map of unique outcome with food, friends, and family members. Michael White suggests that the therapist build a scaffold via questions that encourage people to fill the gaps between the unique events that currently describe certain aspects of their relationship with food, friends, or family and their past experiences, values, and hopes. This scaffold assists people to mobilize their life experience and exercise their imagination and their meaning-making resources. As an outcome, the alternative story lines of people's lives are strengthened and more deeply rooted in history, the gaps are filled, and these story lines are clearly named (White, 2005). Through these conversations a new narrative is constructed in relation to the person's eating, who s/he is, what s/he wants, how s/he manages without an eating disorder, how s/he handles life, how the narrative of his/her social status is changing, and how the narrative of his/her functioning and abilities to free him/herself from the eating disorder is changing. Patients still do not feel secure and complete agency with respect to this new story and often try to silence the achievement in front of parents so as to avoid external pressures to reduce treatment intensity or to make more rapid progress.

Definitional ceremony and outsider witnesses interviewing. To affirm and amplify the patients' achievements we engage in the definitional ceremony metaphor practice rituals, which were drawn from the work of Barbara Meyerhof (Myerhoff, 1986) by Michael White, a cultural anthropologist, and have developed therapeutic applications of this metaphor. In this therapeutic field, people are given the option of telling/performing the stories of their lives before an audience of outsider witnesses. The outsider witnesses his/her response by retelling certain aspects of what has been heard. Definitional ceremony structures usually include multi-layered stories of people's lives using images or phrases that stood out in what was heard.

3.6 Phase 5: recovery and maintenance

As time passes, the patient's eating behaviors and weight status become normalized and stabilized in the long term. Other areas of life become normalized, as well. Treatment intensity is low. The patient experiences self-acceptance.

Objectives

The objectives of this phase include the farewell process; gathering assessments and summaries, and relapse prevention strategies.

Means

At this phase, the patient's file is summarized, as each therapist gathers the specific journey process with its specific tools. There is a collaborative summation meeting, and the setting of a follow-up plan.

STAGE	Dietician Role, Treatment Focus	Psychotherapist Role, Treatment Focus	Family Therapist Role, Treatment Focus	Clinical Mentors Role, Treatment Focus
Choosing Site	Preliminary intake session with professional manager to understand collaboratively (using externalizing language) how problem has come into patient's life, what ED has taken from him/her, and how, towards helping patient and his/her family consider the treatment plan offered to them.			
1 **From partial recognition to full acknowledgment**	• Nutritional assessment • Engaging patient with ED's impacts • Therapeutic alliance • Externalization of ED • Exploring eating issues	• Psychological assessment • Engaging patient with ED's impacts • Therapeutic alliance • Unmasking ED's intentions and tactics • Naming the current relationships with ED and future wishes • Exploring patient's wishes beyond ED (longings?) • Recognizing the unwanted part of ED	• Parents only • Psycho-education to foster recognition of illness' signs, illusions, traps, anti- vs. pro-ED parenting style • Parents + patient • Exploring losses in the family space due to ED • Assessment of family dynamic • Therapeutic contract • Design treatment goals around values	• Therapeutic contract • Common goal, mutual expectations • Soothing meal companions, representing healthy self-caring image, which counters maladapted patterns of interaction, cognition, behavior • Emphasizing creation of coalition to achieve patient's aims • Reflecting pro- and anti-ED behaviors
2 **From acknowledgment to clear cognitive stance against eating disorder** **Guiding towards turning points**	• Externalization and mapping out anti- and pro-AN/BN thoughts and behaviors • Expanding patient's influence on problem • Responsibility around food is between patient and family member or mentor	• Mapping out anti- and pro- AN/BN thoughts and behaviors related to emotional difficulties (*not* related to food) • Recognizing elements enabling ED penetration and control: trait, personal, social status, cultural, and familial factors	• Mapping out anti- and pro- AN/BN behaviors in the family • Recognizing familial dynamics enabling ED penetration • Exploring unique outcomes in which family resisted the dominant story and performed anti-ED steps	• Continued externalization • Monitoring anti-ED voice and behaviors • Forming strong coalition reflecting in real time • Helping patient overcome pro-AN/BN thoughts and behaviors
3 **Against the "patient" status**	• Expansion of options around physical goals • Independence around food is encouraged • Dietician's role gradually transfers to that of a witness, reflecting the changes patient experiences in different areas of life after gaining freedom from ED • Using guiding style when noticing stiffness around food issues	• Monitoring progress in coping skills, recognition of self-identity values, wishes, events, other developmental steps achieved during struggle against illness, done mainly via focus on unique outcomes and the strength and values behind these events • Selective reflections on advantages of healthy status and of self-care • Discussing general coping skills, handling conflicts, social skills, self-	• Identification and expansion of options towards resistant stance against nurturing ED in particular and illness in general in family surroundings • Monitoring unique outcomes, re-writing richer familial narrative story of stronger familial identity, wishes, and demeanors • Emphasizing new continual demeanor to create,	• Focus on new occupations, relationships, and identity formed • Mentor moves to passive place

STAGE	Dietician Role, Treatment Focus	Psychotherapist Role, Treatment Focus	Family Therapist Role, Treatment Focus	Clinical Mentors Role, Treatment Focus
Choosing Site	Preliminary intake session with professional manager to understand collaboratively (using externalizing language) how problem has come into patient's life, what ED has taken from him/her, and how, towards helping patient and his/her family consider the treatment plan offered to them.			
		regulation, self-control issues, other conflicts	essentially, a new narrative and not a series of sentences	
4 **Re-authoring life** **Re-gaining self-agency**	• New narrative regarding food • Focus on normalization of eating behavior • Only when choices are independent and without intervention of the disorder are decisions transferred to patients • Dietician takes role of witness to changes	• Re-writing a new narrative in relation to who I am, what I want, how I manage without ED, how I handle situation • Exploring new ways to cope with these issues and why patients can be assured that ED has no reason to come into their life anymore	• Re-writing of the family identity • Glorification of unique event and what it means in relation to the new family identity	• Parting from mentors • Patients perceived as if almost normal, mature adolescents
5 **Recovery and maintenance**	• Practicing normalization with eating behaviors and stabilizing long-term weight status • Relapse prevention plan	• Treatment becomes overbearing – request for lower intensity • Dealing with mourning over the years that were "lost" and parting • Discussing separation issue	• Dealing with farewells • In the family, developing the attitude toward separation as part of a process in which one opens, as a growth step, as a source of pride to parents	

Table 1. Stages of engagement and recuperation from eating disorders (ED)

Journey closure. "And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom." (Anais Nin) The journey from denial to partial or full recovery witnesses a whole process of development in the therapeutic relationship between patient and therapist. At the same time, the therapists' knowledge, creativity, and insights grow remarkably, and a richer story for all parties is created. During the last few months of treatment, patients are invited for relapse preventions and follow-up sessions with the dietician, as needed.

4. Conclusion

Narrative and motivational counseling share reliance on patients' personal agency rather than on a relationship of power. Both encourage collaboration, evocation, and autonomy, empower people, and strive to help them take steps towards actualization of the values that are important to them. Both use unique communication skills to manage ambivalence and "dominant stories" often associated with chronic diseases. The advantages of integrating these approaches within traditional counseling offer some promise in tackling eating disorders with a transdiagnostic orientation, which addresses the dynamics and needs of comorbidities while treating the eating disorder effectively.

5. Acknowledgment

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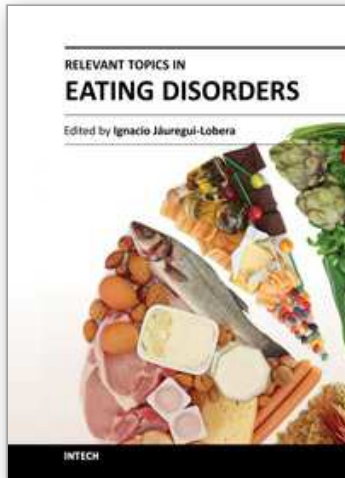
Relevant topics in Eating Disorders

Edited by Prof. Ignacio Jáuregui Lobera

Eating disorders are common, frequently severe, and often devastating pathologies. Biological, psychological, and social factors are usually involved in these disorders in both the aetiopathogeny and the course of disease. The interaction among these factors might better explain the problem of the development of each particular eating disorder, its specific expression, and the course and outcome. This book includes different studies about the core concepts of eating disorders, from general topics to some different modalities of treatment. Epidemiology, the key variables in the development of eating disorders, the role of some psychosocial factors, as well as the role of some biological influences, some clinical and therapeutic issues from both psychosocial and biological points of view, and the nutritional evaluation and nutritional treatment, are clearly presented by the authors of the corresponding chapters. Professionals such as psychologists, nurses, doctors, and nutritionists, among others, may be interested in this book.

How to reference

In order to correctly reference this scholarly work, feel free to copy and paste the following:

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