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BODY IMAGE PSYCHOTHERAPY IN ANOREXIA AND BULIMIA NERVOSA – AN INTEGRATIVE APPROACH: APPLICATION OF PSYCHODYNAMIC PSYCHOTHERAPY AND PSYCHODRAMATIC TECHNIQUES

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Summary

Objectives: The article presents proposal of of implementing an integrative approach to body image therapy for patients with anorexia and bulimia nervosa. The integrative approach proposes to consider techniques of the psychodynamic therapeutic paradigm as well as psychodrama and/of cognitive-behavioral techniques. The sample consisted of 121 females with eating disorders (bulimia nervosa, anorexia nervosa, binge eating disorder).

Methods: Psychometric and clinical methods: the Contour Drawing Rating Scale by K. Thompson and the Gray Eating Disorder Inventory by D. Garner (by C. Żechowski) the Sociocultural Attitudes Towards Appearance Scale — 3, SATAQ-3 by K. Thompson.

Results: The study identified 4 psychological types of females with eating disorders (i.e. neurotic, youth/narcissistic, impulsive and perfectionist). Common elements as well as differences were found in the body image psychotherapy of females in the sample.

Conclusions: The work also includes considerations for providing therapy to the mentioned four types of females who suffer from eating disorders.

Introduction

The aim of the paper is to present the results of own studies, indicating the proposal to include integration of psychodynamic and psychodrama techniques in psychotherapy in the treatment of people suffering from anorexia and bulimia nervosa. The proposals made in this paper, for application in therapeutic work upon body image, have been developed for at least two reasons. First of all, the many years of experience I gained as a psychotherapist conducting therapies for persons with anorexia, bulimia, or psychogenic overeating, triggered numerous reflections concerning work on body image. The psychodynamic approach dominated among the therapeutic techniques. Nevertheless, in the course of therapeutic processes conducted using

psychodynamic approach, attempts have also been made to include techniques based on action into efforts focused on reducing body image distortions and getting an insight into psychological mechanisms underlying body image distortions. The most frequently used ones included behavioral – cognitive techniques, and psychodramatic techniques (groups or monodrama therapy). Second of all, the results of own studies concerning attitudes towards the body in women with eating disorders indicated significant differences existing between study subjects, regarding the presented profile of psychological characteristics profile and attitudes towards the body [1].

It is worth pointing out that the psychodynamic approach (both in explaining psychological mechanisms of eating disorders, and in the interpretation and discussion of results), is not in contradiction with the suggestion that in the complex therapeutic process it is worthwhile to consider the integration of psychodynamic therapy with therapy based on action and psychodramatic techniques. This applies in particular to therapeutic work on distorted body image.

Statistical analysis of the results of studies performed on the population of 121 women suffering from eating disorders allowed to distinguish among them four different profiles of psychological characteristics, as well as emotional and cognitive attitude towards the body. Those profiles have been called psychological types of women with eating disorders, and as it has been suggested to consider - in body image therapy process - each of the psychological types distinguished, to integrate various therapeutic techniques, e.g. the psychodynamic approach with psychodramatic techniques as well as the behavioral- cognitive ones. Third of all, the differences observed within groups, between persons suffering from anorexia and bulimia nervosa, which concerned experiencing of one's bodily integrity and body image, may be in connection with the profile of psychological (personality) characteristics of those people. The process of therapy – lasting in time – of the group of patients discussed, as well as the factors referred to above may justify the introduction of various therapeutic techniques in the psychotherapy of people with eating disorders. Due to the specificity and diversity of therapeutic techniques, suggested for consideration in the psychotherapy of distorted body image in patients with anorexia and bulimia nervosa, the proposed approach has been called integrative one.

Anorexia and bulimia nervosa are diseases in which "the soul suffers and the body is ill at the same time"[2]. Medical and psychological means applied in order to protect the body against self-destruction are important elements of every stage of treatment concerning people with anorexia or bulimia nervosa. Psychologically based efforts to stimulate the health-conscious attitudes to the body and behavior during psychotherapy process are important in the recovery process such people go through. In the entire treatment process, it is vital how to work upon distortions of body image in people suffering from anorexia and bulimia so that the treatment is effective and leads to recovery.

Corporeal and spiritual existence of a person form an indissoluble whole [2, 3]. From the perspective of theories of psychoanalysis, one can perceive anorexia or bulimia nervosa as a group of chronic somatic diseases which – irrespective of how they are named in the medical language – invariably have self-destructive consequences for the person suffering from them, both physical and psychic ones [2, 3].

Contemporary psychiatric and psychological literature confirms the necessity of multifaceted approach to treatment of that group of patients. The research conducted in recent years indicates that it is justified to depart from therapeutic models focused in treatment upon a specific type of disease, and concentrate instead upon the trans-diagnostic model, in which the direction of treatment is adjusted not only to diagnosis of nosological units, but also to the psycho-social mechanisms of eating disorders [4-11].

Defining, in the process of body image distortions therapy, the approach referred in this paper as integrative one, we point out the nonexclusive multifaceted type and variety of psychological mechanisms underlying body image distortions and experiencing one's own body. In the understanding of the genesis of psychological mechanisms that form the background of the health problem discussed here, both the contemporary theories of psychoanalysis, psychodynamic approach [2-5], and cognitive theories of dissatisfaction with the body [6-11] or socio-cultural theories [12-18] have been taken into account. I understand the socio-cultural influence of mass media also as recognition of the vital role of internalized family-derived patterns in the development of the image of corporeality in a person suffering from anorexia or bulimia nervosa.

The research problems concerning the issue of diagnosis and psychotherapy of eating disorders are reflected also in Polish literature of the subject, nevertheless those studies have been made on small populations of subjects [1, 2, 7-11, 19-34].

As regards contemporary research, published in the years 2014-2016, referring to the issues of integrating various approaches in eating disorders psychotherapy, it is worth indicating the presence of such reports, which concern the integration of psychodynamic approach with behavioral-cognitive one [35-38]. Empirical studies reported in the publications from recent years (2010-2016) refer mainly to the area of integrating various forms of therapy of eating disorders, yet rarely do they directly allude to the integration of psychodynamic therapy with psychodrama techniques [39, 40].

Taking into account the fact that empirical descriptions of research concerning psychotherapy of body image distortions - concerning the Polish population of people suffering from eating disorders – are significant due to the ever valid need to search for efficiency in treatment of such people; thus the research in that subject was initiated.

In the introduction to this paper, the main reasons have been provided, explaining why the notion of integrative approach in the process of psychotherapy of body image distortions has been introduced. It is worthwhile to take into consideration yet another important factor, which allows to explain the heterogeneous experiencing of one's own corporeality and the level of body image distortions in eating disorders. That factor is personality structure of persons suffering from anorexia, bulimia, or compulsive overeating; that structure is usually differentiated and independent of medical diagnosis. In the theoretical assumptions made for the model of own studies, as well as the assumed attitude to psychotherapy of body image distortions in women with anorexia, bulimia, or compulsive overeating, reference was made – among other things - to the model of pathologies in the organization of personality structure, suggested by Otto Kernberg [34]. It has been assumed that, independent of the diagnosis of anorexia and bulimia nervosa in a given person (ICD10), each of them demonstrates a differentiated type of personality structure: from neurotic one to borderline cases and psychotic structure. Not only the manifestation and its intensification, but also (or perhaps first of all) the

level of pathology in the organization of personality structure, determine the direction and psychotherapeutic procedures applied in the course of the entire treatment process. It should be noted that a vital structure, which undergoes destabilization in the course of the disease, is the emotional and cognitive experiencing of one's corporeality (structure of corporeal ego). The patient suffering from anorexia or bulimia nervosa has many differentiated defects in the emotional and cognitive experiencing of one's body (negation of one's body), as well as defects in the perception of stimuli coming from the body. We refer here to the difficulties occurring in differentiation between hunger and satiety. When a person is not able to realize her/his own frustrated needs, emotional deficits, and is unable to solve her/his internal conflicts, such a person most often suffers from a somatic disease and experiences manifestations from the body. It is through the body that we often get to know the symbolism of denied internal conflict in a person suffering from anorexia or bulimia nervosa.

In the complex process of treatment (medical, psychotherapeutic, and dietary treatment) of the discussed group of patients, multiple directions of treatment are invariably considered, which depend on the theoretical therapeutic paradigm assumed in treatment. Each of the theoretical paradigms assumed in psychotherapy (e.g. psychodynamic, behavioral-cognitive, humanistic-existential, or systemic one) in a sense imposes the goal-focused intervention techniques used in therapy, the goal being recovery; this also implies the equalization of disturbances in cognitive and emotional experiencing of one's corporeality.

In the research assumptions I made and the goal of therapy concerning the psychotherapeutic process, including efforts to change the distorted body image in a person suffering from anorexia or bulimia, those efforts may be multidirectional and may indicate – in various stages of treatment – the therapeutic procedures valid for the process of corrective changes. On the one hand, the directions and therapeutic techniques applied in working upon correcting the body image will depend on the aggravation of anorectic or bulimic manifestations. On the other hand, the therapeutic procedures applied will depend on the personality structure of the patient (neurotic, borderline type, psychotic one). Each of the personality structures mentioned, manifests a – specific for a pathology of given structure – differentiated configuration of intensification of psychological traits and socio-culturally developed attitudes towards the body, which determine the strength of destructive (restrictive or impulsive one) behaviour towards the body in the examined patients. It seems understandable that the domination and constellation of specific socio-cultural psychological conditions (internal conflicts concerning the process of separation and individualization of image) as well as specificity of destructive behaviour towards the body, in persons with neurotic organization of personality structure, determine another direction of therapeutic procedures in work on body image, than in case of persons who have borderline or psychotic personality structure. It may be assumed – in congruence with the basic assumptions of organization of personality structure pathologies acc. to the object relations theory – that persons with symptomatology of anorexia or bulimia nervosa, with borderline or psychotic personality structure, shall manifest definitely higher level of psychopathology of the corporeal ego structure (body image) and shall experience their own corporeality in a more destructive (self-destructive) manner [8,26,71].

The process of treatment of people suffering from anorexia and bulimia, implemented in accordance with the standards of contemporary science (medical and psychological one) should use the so-called specific (intentionally planned medical and psychotherapeutic activities, in

line with the theoretic paradigm concerning the understanding of psychopathology of the disorder and psychotherapy process, as assumed by the therapist), and non-specific (universal) agents, supporting the therapy of patients. They include, first of all:

- therapeutic relation focusing on the development of cooperation (alliance between the patient and the therapist/doctor),
- evoking positive emotions in the relation with the doctor/ therapist, and negative emotions in relation to the previous life experiences, as well as evoking emotions that are adequate to the recent events,
- gaining new knowledge, acquiring new skills, and practising new behavior patterns.

Besides the factors listed above, important influence upon the course of treatment in such persons is also exerted by other elements, e.g. the present psychophysical condition of the patient. In many situations, for example in the condition of physically wasting the body (that is, physiological parameters related to health state, e.g. arrhythmia of the heart, too low body weight, have to be corrected immediately, as they constitute a life threatening condition, and may lead to death) the people suffering from anorexia or bulimia nervosa need to be treated as inpatients. In such cases, no psychotherapeutic efforts make sense, which are undertaken to make the patient aware of the internal conflicts and psychological mechanisms s/he is not aware of, underlying eating disorders. The patient is so destroyed physically that s/he is not able to work intellectually or use her/his emotional resources. Psychological assistance for the regulation of behavior towards the body often requires supporting the decision about hospitalization, which is not always accepted by the patient, arousing resistance and denial of the reasoning of the doctor and therapist. The patients suffering from anorexia nervosa, not only of restricting type, block their emotional experience of the body – due to multiple psychological mechanisms of the disease (denial, primitive idealizing, omnipotent control, splitting, projective identification, rationalizing, intellectualization) – as well as apply cognitive distortions (through preconceived notions and perception) of its image. Anorectic patients see something different than their doctors, psychologists, or psychotherapists – who realistically assess the actual psychophysical condition of the patients – as well as their close ones, from social environment (parents, siblings, partners, friends, etc.). Lack of identification with the disease, and distortions of the mental world do not allow to assess realistically the life-threatening character of the disease and the destructive attitude towards the body that it brings about.

Analyzing the universal healing factors in psychotherapy, regardless its theoretical paradigm, building a positive emotional relation between the patient suffering from anorexia or bulimia nervosa and the therapist/doctor is at the same time the basis for developing a therapeutic alliance between them. Thus, it is a starting point for further treatment directed at the patient and an introduction to changes, which may take place in the patient's life and attitude towards the body. The therapeutic alliance provides the basis for acquiring new knowledge, which - by training of new (corrective) behaviours towards the body - leads to change. Therapeutic alliance and the relation between the patient and therapist of eating disorders are of substantial significance, from the first to the final stage of treating that group of patients. Nevertheless, it seems important to consider, in the treatment process of the distorted body image, also the so-called specific healing factors, depending on the specificity of personality

structure and psychological characteristics of the person suffering from the disturbances discussed.

Empirical studies directed at diagnosing the psychological and socio-cultural predictors of attitudes towards the body have been conducted by the author of this paper on the population of 121 women, age range 20-26 yrs, suffering from eating disorders. The studies have been described, together with results, in a complex manner in the monograph entitled *Postawy i zachowania wobec własnego ciała w zaburzeniach odżywiania* (Attitudes and behaviour towards the body in eating disorders), published in 2014 by Wydawnictwo Naukowe PWN[1]. This paper presents only that aspect of results of own studies, which became the basis for reflections upon the proposed model of suggestions worth considering in psychotherapy of distorted body image in patients with anorexia and bulimia nervosa.

Research material

Due to the goals and topic of this paper, only the basic data will be presented, which allow to provide the characteristics of the study, study group, as well as the research methods applied. Further on, empirical data will be presented, as well as the main proposals resulting from them, for consideration in conducting psychotherapy of body image for persons suffering from anorexia and bulimia nervosa.

Characteristics of the study group

The selection to the group followed the non-probability principle: 121 women not suffering from eating disorders, age range 20-26 yrs (control); and 121 women, age range 20 to 26 yrs, with medical diagnosis (clinical group) of: anorexia (ICD-10 F50.0;F50.1) including the restricting type (N=29, age: 21.3 yrs BMI=16.7), anorexia – bulimic type (N=30, age:22.3 yrs, BMI=17.8), bulimia nervosa (ICD-10 : F50.2; F50.3; N=30, age: 21.3 yrs, BMI=20.63), psychogenic binge eating disorder (ICD-10: F50.4; N=32, age:24.1 yrs, BMI=24.03).

Study procedure

Examinations of individual women with eating disorders took place within the organization structures of ambulatory health care, that is in centres for treatment of eating disorders, which have the following in their structures: day ward for treatment of neuroses and eating disorders, psychiatric outpatient clinics, outpatient clinics for treatment of neuroses.

All the health care unit met similar criteria for provision of medical and psychological services for the above group of patients. The criteria included regular and obligatory checking of the psychophysical condition of study subjects (body mass, BMI and medical check-ups, medical and psychological consultations, as well as dietary consultations, depending on medical recommendations).

As regards the selection of methods for achieving the research aim, besides the psychometric criteria, an important issue was the establishment of criteria for clinical interpretation of research data, obtained via questionnaire and clinical (projective) methods. Those criteria allowed to determine the intensification of all variables studied, in the dimension of: proper – improper for maintaining health (indicating the variable intensification, defined as the so-called clinical level – improper for the health).

The study procedure comprised three stages:

Stage I – pilot study, conducted on the population of 140 Poles, to collect source material for building two study tools, serving the purpose of measuring the study variables included. On the basis of assessing the reliability and integrity, with the application of Cronbach's alpha for items composing the study tools constructed, the structure of factors has been singled out, which form the basis for the Questionnaire for Socioacultural Attitudes Towards Appeareance and Body Image Scale - SATAQ-3[1].

Stage II – studies conducted on the population of 121 women with eating disorders (clinical group), and 121 women without eating disorders (control group), with the application of clinical and psychometric methods [42-45]. In the description of indicators of psychological variables of the own study model (profiles of psychological characteristics and socio-cultural factors), measures of central/main tendencies (mean values and standard deviation) have been considered. Statistical documentation of differences between the clinical group and control allowed to indicate the incorrect intensification level concerning the studied psychological variables in women with eating disorders. Due to the absence of normal distribution, for the purpose of comparison the averages we applied the Mann-Whitney U non-parametric test for two groups, and for comparison of body image indicators – the chi-squared test.

In stage III of the study procedure - cluster analysis by k-means method has been applied for conducting inter-group differentiation in the group of women with eating disorders. As a result of k-means cluster analysis, clusters have been identified, which has been followed by comparisons between them with the ANOVA analysis of variance (F-test by Fisher).

The cluster analysis conducted indicated the existence of four differentiating clusters in the studied population of 121 Poles with eating disorders.

Detailed description of the organization of research, the study group, as well as study procedure has been provided in the monograph by the Author, published in 2014 [1]. The studies were conducted in the years 2007-2012 in neuroses treatment centres, eating disorders treatment centres, mental health outpatient clinics, and outpatient clinics for treatment of neuroses, all located in Poland. Consent has been granted for conducting the study, from the Ethics Committee of the Faculty of Education Studies and Psychology of the University of Silesia (Komisja Etyki Wydziału Pedagogiki i Psychologii Uniwersytetu Śląskiego w Katowicach).

Research methods

Clinical and psychometric methods have been applied in the study. Each study subject participated in a multi-stage psychological examination, carried out in the outpatient clinics, in which the treatment of every study subject was subsequently applied. The time of psychological examination comprised a cycle of at least three psychological consultations. The study methods that were important due to the topic of the study comprised:

1) clinical history taking (measurement of body mass index - BMI, socio-demographic data: age, sex, place of residence, marital status)
2) body image drawing (measurement of body image indicators: body scheme and body orientation – awareness of body limits)

3) Contour Test (Contour Drawing Rating Scale) – developed by Thompson and Gray – measurement of self-assessment of body image [41]
4) EDI (Eating Disorder Inventory) developed by D. Garner (adapted by C. Żechowski) – measurement of psychological traits typical for persons with eating disorders [37,38]. The following psychological variables have been measured: dissatisfaction with the body, interoceptive awareness, "bulimic" thinking, perfectionism, self-esteem – feeling incompetent and inefficient, interpersonal relations – uncertainty and distrust attitude, fear of gaining weight (strive for being slim), fear of one's own maturity [4, 42, 44]
5) The Questionnaire of Socio-cultural Attitudes Towards Appearance Scale – 3, SATAQ-3 developed by Kevin Thompson et al.) – measurement of socio-cultural attitudes concerning the attitudes and behaviour towards the body [45].

Results

The obtained results of the research have certain limitations imposed, e.g. due to the cross-sectional rather than longitudinal studies, specificity of the study group: age and sex (comprising only women being young adults, omitting other age categories), as well as the selection of research tools. The exclusion and control of the above factors at the time of undertaking own studies was not possible, while the selection of tools for measuring psychological variables stemmed from the source material, which confirmed the justifiability of using the clinical and psychometric method applied, among others the Eating Disorder Inventory (EDI), in the study procedure. In planning the problems to be studied in future research concerning the area discussed, it is worth considering the factors mentioned above, which take into account – among other things – the difference in age range, measurement of studied variables both in women and in men with eating disorders.

Nevertheless, the own studies reported here constitute the empirical material that has been rarely verified in Polish research concerning eating disorders. Their innovative character results, for example, from the attempt to isolate from the 121 study subjects the psychological types of women suffering from anorexia, bulimia, or binge eating disorder.

Figure 1 presents the mean values of standardized results only for those psychological and socio-cultural variables, which significantly differ for the defined four clusters of subjects.

Due to the substantially different distribution and intensification of psychological and socio-cultural variables in individual clusters of women in the study group, those clusters have had names attached, as follows: neurotic type (cluster one), perfectionist type cluster two), impulsive type (cluster three), and juvenile-narcissistic type (cluster four).

On the basis of the description of data obtained via clinical method (history taking, observation, projective tests, psychodynamic diagnosis of personality structure) clinical characteristics of the studied psychological and socio-cultural variables has been prepared for four psychological types of women suffering from anorexia and bulimia nervosa (Tab.1).

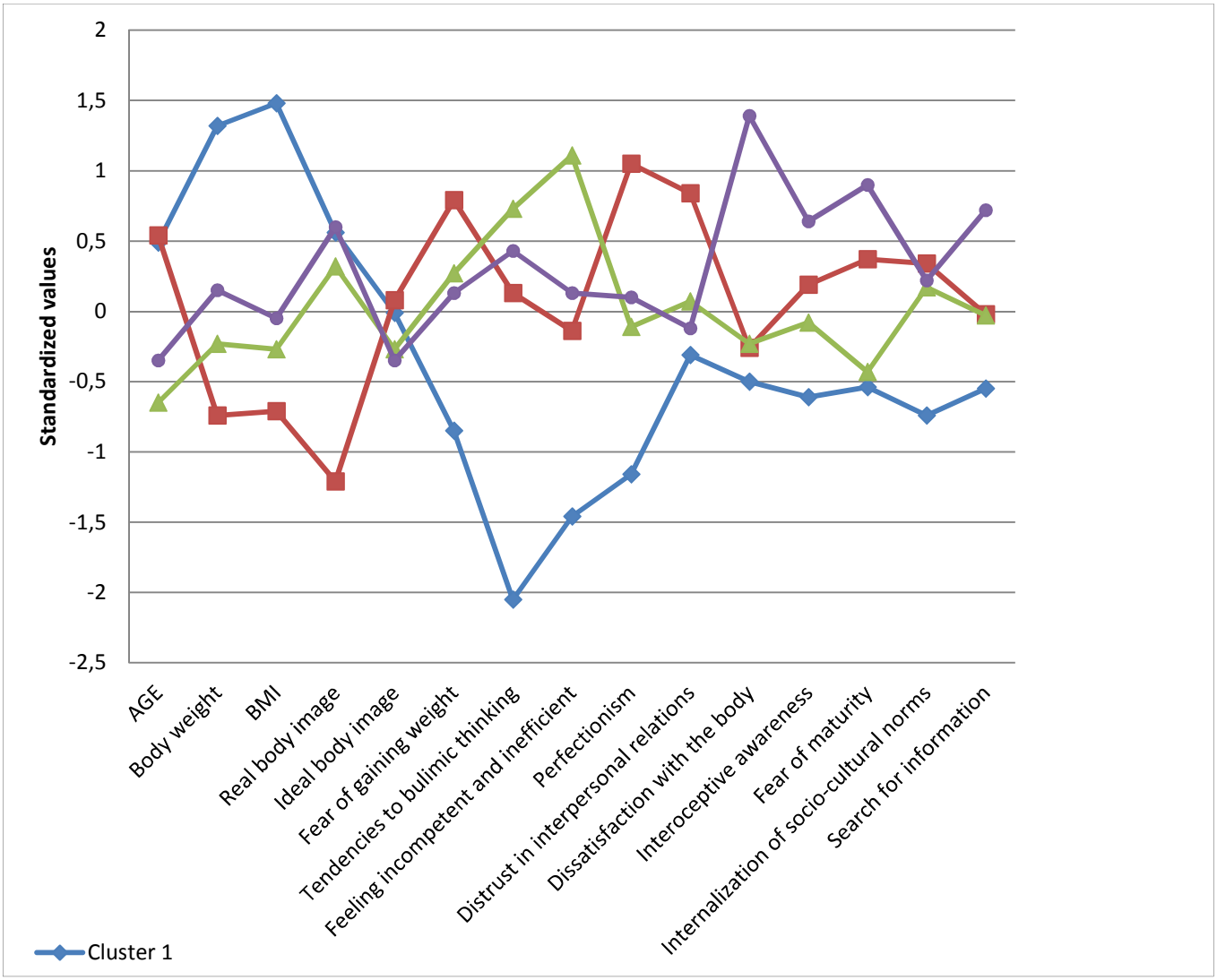

Fig.1. **Results of cluster analysis by the k-means clustering. The presentation of significantly differentiating standardized mean values, concerning psychological and socio-cultural variables in the studied population of Polish women suffering from eating disorders (N=121).**

Table 1. **Clinical characteristics of psychological variables in psychological types of women with eating disorders (N=121).**

Neurotic type	Perfectionist type	Impulsive type	Juvenile-narcissistic type
Elevated level of dissatisfaction and lack of acceptance of one's own body	High level of dissatisfaction and lack of acceptance of one's own body	High level of dissatisfaction and lack of acceptance of one's own body	Very high level of dissatisfaction and lack of acceptance of one's own body
Domination of ideal body image over one	Domination of ideal body image over one	Domination of ideal body image over one	Domination of ideal body image over one
Correct or slightly reduced interoceptive awareness	Markedly reduced (incorrect) interoceptive awareness	Markedly reduced (incorrect) interoceptive awareness (substantial deficits in that respect)	Markedly reduced (incorrect) interoceptive awareness

Correct or slightly elevated level of perfectionism	Very high level of perfectionism	Very high level of perfectionism (abnormal for maintaining health)	High level of perfectionism (abnormal for maintaining health)
Slightly elevated fear of gaining weight	Very high level of fear of gaining weight	High level of fear of gaining weight	Elevated fear of gaining weight
Bulimic thinking - within norm or slightly elevated	Bulimic thinking - within norm or slightly elevated	Highly elevated bulimic thinking	Bulimic thinking – within norm or slightly elevated
Self-assessment - correct result	Self-assessment - correct result	Self-assessment - incorrect result – indicating significantly reduced self-esteem – feeling valueless	Self-assessment - correct result
Interpersonal relations - without too much uncertainty and distrust	Feeling of uncertainty and distrust in interpersonal relations	Feeling of uncertainty and distrust in interpersonal relations	Feeling of uncertainty and distrust in interpersonal relations
Very high level of fear of maturity	Very high level of fear of maturity	Fear of maturity within norm	Very high level of fear of maturity
Very high level of Internalization of socio-cultural norms promoting accepted standards of body image	High level of Internalization of socio-cultural norms promoting accepted standards of body image	Very high level of Internalization of socio-cultural norms promoting accepted standards of body image	High level of Internalization of socio-cultural norms promoting accepted standards of body image a
Psychodynamic diagnosis – personality traits: obsessive and compulsive, timid	Psychodynamic diagnosis – personality traits:obsessive and compulsive, anankastic, narcisistic	Psychodynamic diagnosis – personality traits: borderline, histrionic, obsessive-compulsive	Psychodynamic diagnosis – personality traits: narcissistic, obsessive-compulsive, timid
Personality structure with neurotic traits	Personality structure of borderline type, psychotic	Personality structure of borderline type	Personality structure with neurotic traits
Anorexia and bulimia nervosa	Anorexia: restricting type, bulimic type	Bulimia nervosa	Anorexia, bulimia nervosa
Clinical data from history taking: absence of traces of self-mutilation, chronic diseases, abuse of psychoactive or behavioral substances, absence of psychic (psychological) traumas as well as violence (psychic, physical, sexual) revealed in history taking. The study subjects – at the time of history taking – were for at least 6 months in a relation, their partnership relations had varying lengths.	Clinical data from history taking: absence of traces of self-mutilation, chronic diseases, abuse of psychoactive or behavioral substances (including alcohol) as revealed in history taking, behavioral dependencies, absence of psychic (psychological) traumas as well as physical and sexual violence in the past. In history taking many subjects provide information about losses of emotionally close persons in childhood , long term separation (from 3 to 6 months, to a few years) from a parent, experiencing	Clinical data from history taking confirm the occurence of various chronic diseases in a substantial number of subjects (e.g. concerning reproductive organs, alimentary tract), body injuries (often self-mutilation), dependence on psychoactive substances (including alcohol), behavioral dependencies, psychic (psychological) traumas experienced in the past and/or continued situation of violence (psychic, physical, sexual) experienced by many subjects in their environment. The study subjects – at the time of history taking –	Clinical data from history taking: absence of traces of self-mutilation, chronic diseases, psychic (psychological) traumas experienced and revaled in history taking and/or continued situation of violence (psychic, physical, sexual) experienced by many subjects in their environment . The study subjects – at the time of history taking – were for at least 6 months in a relation.

	psychic violence . Episodes of using psychoactive substances in order to keep body weight in line with the need to have idealized body image. The study subjects – at the time of history taking – were in a relation for no more than 6 months, or had no partners.	were for at least 6 months in a relation.	

Discussion

On the basis of the statistical analysis of results obtained from psychometric and clinical methods, as well as the clinical characteristics of selected data from history taking and medical documentation, the initial report has been prepared, concerning the main directions of therapeutic action concerning correcting the distorted body image in study subjects. In that image – irrespective of the cluster which the subjects represent – high level of dissatisfaction with one's own body dominates, with simultaneous desire to have an ideal body image (not adequate to the BMI). The remaining psychological and socio-cultural variables, as well as the selected clinical indicators (data from clinical interview) provide the psychological characteristics of women from the four psychological types, in a diverse manner [Tab.1]. Taking into account the above data I considered that different configuration of psychological and socio-cultural variables in respective clusters may be of importance for the specificity and efficiency of the process of psychotherapy of body image distortions in patients with anorexia and bulimia.

In the first stage of therapy, when building the therapeutic alliance and health-promoting motivation for treatment, we usually make decisions concerning a further stage of therapeutic management of the patients discussed here. Together with the reference to the obtained results of own studies, as well as the obtained psychological typology of women with anorexia and bulimia nervosa, certain guidelines have been suggested for undertaking psychotherapeutic actions in the treatment process of the presented group of patients. Because of the proposal, concerning also the inclusion of behavioral-cognitive techniques, as well as psychodramatic ones, in the therapeutic management of distorted body image, conducted applying psychodynamic approach (individual and group therapy), the proposed therapeutic approach has been called integrative. Presented below is the proposal of main suggestions to be considered, as those which may support the psychotherapy process in case of body image distortions in women with anorexia and bulimia, depending on the psychological type they represent. Regardless the differences in that process, indicated below, it is worth noting that at the forefront of treatment are the non-specific (universal) agents, which refer to the development of empathic relation between the therapist (psychologist) and the patient, based on the authenticity and openness of relations. They are considered to be significant in all therapeutic approaches. Starting to build the therapeutic alliance, we should take into account – as part of the process of reaching diagnosis – the specificity and type of manifestations, the

diagnosis of emotional, cognitive, and behavioral distortions concerning body image in the ill person. Moreover, irrespective of the proposed actions that support the process of psychotherapy of body image distortions, taking into account the psychological types identified, the treatment process invariably involves the necessity of monitoring - by medical personnel – of body weight and somatic state of patients with symptoms of anorexia and bulimia nervosa.

Proposals and remarks for consideration in activities that support the process of psychotherapy of body image distortions in women of neurotic and juvenile-narcissistic type.

Taking into account the configuration of psychological and socio-cultural variables, the age of subjects (late adolescence, young age) it can be assumed that the level of the profile of psychological traits, socio-cultural variables and symptoms may confirm the neurotic features of personality structure in the women representing the two psychological types discussed. Taking into account the age of subjects, it may be assumed that the profound fear of maturity in the subjects may, in a significant degree, block the psychosexual needs and sexual desires, connected with achieving separation abilities and individualization (the complex identity and personality of the adult is formed). This assumption may be confirmed in the literature of the subject, which indicates the importance – in the course of eating disorders in young adults – of psychological mechanism of regression (via symptoms) to earlier phases of development, among them the unsolvable oedipal complex (S. Freud) or the phase of separation and individualization (M. Mahler). The ambivalence – resulting from the age of adolescence and youth – in thinking, emotional experiencing, and behaviour of patients may activate in them the anorectic symptoms, destroying the body from the level of regression to oedipal phase, which is usually connected with blocking the functioning of the sexual drive sphere in a person. The bodily manifestation often becomes a symbol of denied and blocked conflicting content, pertaining to sexual drive and the separation-individualization process [1, 3, 4, 7-10, 20-22].

Because of specific functioning of the personality structure, qualified acc. to study results to the so-called neurotic structure [8], women belonging to neurotic and juvenile-narcissistic type may have the possibility of disclosing the following, also in the psychotherapy process: neurotic defence mechanisms, stable ego (correct testing of reality, absence of distortion of body limits, and identity disorders). Thus, from the beginning of the psychotherapy process, better conditions and indications for insight-oriented psychotherapy exist, also as regards work concerning body image and experiencing of one's own corporeality.

Disease manifestations (often connected with the body) are a symbolic reflection of internal conflicts, to a large degree. As can be concluded from own studies, distorted body image (negation of the real body image) is also largely influenced by internalization and pressure of socio-cultural factors (particularly mass media). Psychodynamic therapy, insight-oriented therapy, individual or group therapy are processes, which the patients suffering from anorexia or bulimia - due to neurotic structure of personality and configuration of psychological traits - can cope with. Work with the body may be supported here by techniques of action, in particular psychodrama and behavioral-cognitive techniques. Stable ego and absence of identity disorders, together with neurotic defence mechanisms provide the basis for receiving and passing information about the patient's body in a therapeutic relation understood as "a meeting

of two bodies: that of the patient and that of the therapist". This entails that the body is not –for both participants in that relation – a source of strong and massive transferences and counter-transferences, which are manifested by the fact that the impressions of the patient and therapist in the therapeutic relation do not resemble a "heavy and murderous battle between various internal conditions and emotions". The therapist, experiencing strong and various emotions in relations with the patient, usually does not reveal in the counter-transference those, which may be compared in descriptions to the loss (disintegration) of her/his own corporeal identity (significant difficulties in experiencing the borders of one's own body, disintegration in experiencing stimuli and sensations coming from the body). In the relation with the patient, the therapist usually has impressions that are adequate to the sensations coming from her/his own body, is able to differentiate them and separate them from the bodily sensations of the patient, maintaining ego-dystonic attitude to the analyzed emotional relation with the patient's experienced corporeality. On the one hand, there is empathy and understanding of the bodily experiences discussed with the patient, on the other hand it is possible for the therapist to experience her/his own corporeality – adequately to the situation of therapeutic relation – and to maintain the distance to the bodily experiences and manifestations presented by the patient. The patient's body and the therapist's body are two separate beings, going through their own experiences.

In the group of female subjects discussed, what dominates is a substantial idealization of the body and denial of the real image of one's own body which – due to the strong socio-cultural influence demonstrated in the study – confirms the need to be considered in the foreground of insight-oriented therapy dealing with psychological mechanisms of disorders (symbolic functions of a disease symptom), as well as paying attention to the importance of internalization of socio-cultural norms and family stories passed through generations, in the process of treatment of the disorders discussed. Insight-oriented therapy will allow to achieve a greater awareness of the patient, regarding the area of conflicts that s/he is not aware of, as the source of self-destructive behaviours towards the body. Due to the specific character of the given period in life, the maintained/preserved ability for reflection upon the world of internal experiences, psychodynamic (focused on the insight) group or individual psychotherapy may constitute an important inspiration for reducing the pathological signs. Enriching the insight-oriented therapy techniques with elements of symptom treatment with the use of psychodrama techniques may increase the insight into symbolic meaning of the disease signs. In case of such patients, it is also good to remember the importance of building a proper emotional relation with the patients, and of exploring the properly understood slightly educational attitude, which would provide the patient with signposts in the treatment process, from the position of being an authority (without pushing, but with clearly determined principles and conditions to be met to get healthy).

Proposals and remarks for consideration in activities supporting the psychotherapeutic process in case of body image distortions in women being of perfectionist and impulsive type

A person with medical diagnosis of anorexia or bulimia, simultaneously manifesting features of a perfectionist or impulsive type, usually presents a psychological characteristics

which, in the patient's transference, often causes specific sensations and experiences, coming from the body, most often described as: "turmoil in the body", "struggle in the body". In symbolic language, this kind of relation with the body may be described as "a kind of battlefield between various experiences", which the patient also encounters in relation with the doctor or therapist. The patient's corporeality, which often – through defence mechanisms of splitting or projective identification – "cut off" her/his own emotions and sensations, is usually connected with the therapist's experiencing similar body sensations and emotions. Oftentimes, the patient's sensations are characterized by lack of integration of various emotions and stimuli coming from the body. Similar things can happen in the counter-transference sensations of the therapist. The latter can also sense a "confusion" in the emotions felt and bodily sensations experienced. This frequently happens due to domination of splitting mechanisms in that group of patients, as well as the developing relation of transference and counter-transference, based on the mechanisms of projective identification. In experiencing one's own body, the patients with eating disorders, belonging to the psychological type discussed here, often experience high impulsiveness or blocking the emotions and stimuli coming from the body. Configurations of psychological traits and personality structures of impulsive and perfectionist type indicate that personality structure of those patients have the features of borderline and psychotic type of personality organization [1]. The configuration of psychological traits, as well as socio-cultural variables, presented in Table 1, together with clinical characteristics of impulsive and perfectionist type, confirm the presence – in those groups of patients – of very significant emotional and cognitive disturbances in experiencing one's own body, greater than in case of persons belonging to neurotic or juvenile-narcissistic type. The substantial distortions in perception and patterns of thinking concerning body image, occurring in women of the impulsive and perfectionist type, may require longer cognitive reconstruction (that is, learning new things, focused adequately to reality) so that recovery is possible. Of assistance in this process – besides the long term psychodynamic psychotherapy conducted – will also be the cognitive and psychodramatic techniques.

Substantial deficits occurring in the structure of psychological functioning, concerning interoceptive awareness, strong impulsiveness and perfectionism, distrust and uncertainty in interpersonal relations (significant difficulties in building emotional relations with others have been demonstrated) are psychological variables, which seriously impede the use of insight-based therapy as dominating form of treatment. Because of the configuration of psychological variables, it is worthwhile to consider, from the beginning of treatment, the application of long-term psychodynamic therapy, based on building emotional bonds, with delay of work focused on insight into psychological mechanisms of disturbances. In the therapeutic process, it is worthwhile to take into account the behavioral-cognitive techniques, as well as psychodramatic ones, particularly in the work concerning stimulation of low interoceptive awareness, or dealing with recurrence of bulimic symptoms. We begin to build the therapeutic alliance, but the patient does not see herself as having a distorted (cognitively and emotionally) image of the body, when she is not aware of how much she destroys the body by what she is doing, I become her mirror as a therapist, a mirror that serves the purpose of being confronted with the real (self-destructive) spiritual and bodily condition.

Configurations and intensification of psychological traits in women of the perfectionist and impulsive type are not conducive to quick and efficient course of treatment. Such profiles

of psychological traits are often intensified in ill persons by resistance and by passive forms of expressing aggression to oneself and the surroundings. In the first phase of treatment we pay particular and undivided attention to establishing the criteria of the contract, in which the determination of body weight criterion, and control of medical parameters are indispensable to conduct the psychological work safely. Consent of the patient for regular body weight control and contacts with physicians, in order to monitor the somatic condition and results of tests ordered is a major thing here.

This does not mean, however, that in case of other psychological types this requirement is not valid. Nevertheless, due to the severity of patient's disorders it needs to be particularly stressed. Monitoring of weight and somatic condition by a physician and medical personnel gives the possibility of relieving the therapist from the obligation of controlling the patient's somatic condition, at the same time enabling safe work upon reduction of symptoms and psychological mechanisms of disorders. Oftentimes, the "educational" attitude modeled by the therapist, towards the patient in whom strong anorectic (restricting) or bulimic (impulsive) symptoms are manifested, serve the purpose of protecting the patient's life. A clear message from the therapist that a person is not able to make a realistic assessment not only of her/his weight but also of the emaciated body, is a proposal to provide support in the process of recovery and establishing a contract for treatment.

Conclusions

In summary of all the study results obtained, we can draw the following general conclusions:

1. Depending on the psychological type represented by a person suffering from eating disorders, in the treatment process one can consider various suggestions concerning the application of therapeutic procedures to support the treatment process in case of women with anorexia and bulimia nervosa.
2. The configuration of psychological traits of lower perfectionism, impulsiveness, deficits in interoceptive awareness, higher self-esteem (absence of intensified sense of being worthless) in women of the neurotic and juvenile-narcissistic type may support the hypothesis that from the beginning of treatment such persons may be more frequently referred for insight-oriented psychotherapy.
3. The configuration of psychological traits in subjects of perfectionist and impulsive type may require psychotherapeutic activities applying psychodynamic approach, focused particularly and in the first place upon building emotional bonds in therapeutic relations. Elements of insight-oriented therapy should be brought in much later, when a positive and substantially grounded (safe) bonds will allow the patient to "accept the content s/he is nescient of" in the consciousness, and turn it into motivation to change.
4. In the course of psychodynamic therapy, working on body image distortions in people belonging to all psychological types, it is worth considering the introduction of elements of behavioral-cognitive techniques and/or action techniques (psychodrama).
5. Due to the small size of the study group, the presented study results have significant limitations, and conclusions pertaining to the entire population cannot be drawn from

them. Nevertheless, they may be a good starting point for further studies in search for factors that would support the psychotherapy of persons with eating disorders.

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