

WORKSHOP OUTLINE

**Alienating patients from the “Anorexic Self”:
Externalizing and related strategies**

**Kelly Bemis Vitousek, Ph.D.
Department of Psychology
University of Hawaii**

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Kelly Vitousek, Ph.D.
Department of Psychology
University of Hawaii
2430 Campus Road
Honolulu, HI 96822
USA

vitousek @ hawaii.edu

ALIENATING PATIENTS FROM THE “ANOREXIC SELF”: EXTERNALIZING AND RELATED STRATEGIES

Definitions and uses

Externalizing symptoms in the treatment of AN:

- featured in a number of influential approaches:
 - Maudsley model of family therapy
 - narrative therapy
 - Montreux model (Claude-Pierre)
 - addiction model
- occasional analogies and/or focal techniques appear in a wider range of modalities:
 - specific strategies recommended by Costin (1997), Treasure & Ward (1997), McFarland (1999), Charpentier (2000)
 - exercise of writing letters to “Anorexia, my friend” and “Anorexia, my foe” (Serpell et al., 1999)
- one popular (if incongruous) name for the externalized entity: the “Anorexic Self”
 - other terms include: “Anorexic Voice,” “Sick Voice,” “Negative Mind,” or simply “Her” or “Him”
 - contrasted with the individual’s “Real Self,” “True Self,” “Healthy Voice,” “Actual Mind,” or whole identity (i.e., “you”)
- three encounters with the Anorexic Self:
 - each incident illustrates why the construct might appeal to the parties who invoked it ...
 - each also suggests how the construct might lead them astray ...

Externalizing is applied in different ways and for different purposes across different treatment models:

- the construct can be seen/used: *strategically, metaphorically, literally*
 - Montreux model:
 - originated as a *strategy*:

“[I] concluded that in order to fight [anorexia], I had to present it to [my daughter] as a separate entity.” (Claude-Pierre, 1997, p. 6)
 - picked up *agency* and *intent*:

“The Negative Mind will use every trick, every gambit to gain the advantage and destroy its victim ... [and] is always conniving methods for mayhem.” (Claude-Pierre, 1997, p. 113)
 - Narrative therapy:
 - not a “literal truth,” but a *metaphor* that fosters a different way of “seeing” AN
 - not a “mere technique,” but embedded in a broader philosophical view (Madigan & Goldner, 1999; Maisel et al., 2004)
 - Family therapy:
 - recognized as a *strategy* that is employed to accomplish a specific goal:

“[The device is used] to give the parents a ‘handle’ on managing the illness” (p. 71)

“In stressing that the patient has little control over her illness, the therapist tries to enable the parents to take drastic action ... when ordinarily they might be reticent to ‘force food’ onto such an obviously frail-looking adolescent.” (Lock et al., 2001, p. 52)

- the construct can be applied to *discrepant* purposes; e.g.:
 - family therapy uses the construct (in part) to justify “taking control” over eating behavior
 - narrative therapy uses the construct (in part) to explain why “taking control” is contraindicated

Current workshop:

- will discuss externalizing strategies collectively - while highlighting some of the theoretical and clinical differences across approaches that use the device
- will focus on *dimensions* of benefit/risk rather than global assessment as helpful/harmful
- will examine the “Anorexic Self” as a metaphor for clinicians’ *own* views of AN

Bases for externalizing AN

Why does the construct of the “Anorexic Self” appeal to therapists and parents?

- the construct seems subjectively valid

- the individual *does* appear to become a “different person” under the influence of AN, with dramatic changes in appearance, behavior, mood state, and interests

- the construct can be used to alienate patients from egosyntonic symptoms

- we can speak ill of the patient’s symptoms without insulting her
Which sounds better?
 - “*You* are selfish ... *you* are dishonest ... *you* are thoughtless”
 - “The disorder has *made you* selfish ... the disorder has *made you* dishonest ... The disorder has *made you* thoughtless”
 - “*Anorexia* is selfish ... *Anorexia* is dishonest ... *Anorexia* is thoughtless”

- we can reinterpret attachment to symptoms

- the individual doesn’t really *want* to restrict her eating, lose weight, or resist treatment - her Real Self has been invaded/infected/colonized by an Outside Force
- preferred metaphors cast the Anorexic Intruder as a crafty, conniving creature rather than a merely bad one

Common themes include:

- militaristic (e.g., the Anorexic Self as terrorist, assassin, dictator)
- satanic (e.g., the Anorexic Self as demon, vampire, alien)
- animalistic (e.g., the Anorexic Self as parasite, spider, octopus)

“[Anorexia is like a] parasite that attempts to consume ... [and] obliterate the true gentle nature of its host.” (Claude-Pierre, 1997, p. 39)

“[Anorexia] is like the wolf who disguises himself as a loving benefactor.” (Maisel et al., 2004, p. 138)

- we can disinhibit disclosure of symptoms
 - common term in substance abuse treatment: "Telling on your addict"
 - symptomatic beliefs/behaviors are more readily confessed when attributed to another culprit
- The advantage of an imaginary playmate: "*He* did it, not me!"

"I felt we had really accomplished something when a patient came for her session and said: 'Can you imagine what the bad guy made me do this time?!' She was not ashamed of what she had done, and could quite freely keep me updated on the most bizarre things she had had to do." (Charpentier, 2000, p. 259)

- the construct preserves our empathy for individuals with AN

- clinicians recognize this advantage for *parents*; e.g.:

"[Externalizing AN] provides us with a much better target for our anger. [Now we have] something to (literally) yell at, threaten, and defy, in a way that never would have been possible if we thought of it as a part of [our daughter]." (Parent quoted in Maisel et al., 2004, p. 240)
- *therapists* may also find it easier to split off "parasite" from "host" or "villain" from "victim" than to come to terms with patients' own ambivalence

- the construct underscores the seriousness of AN

- family therapy makes most explicit use of the device for this purpose:

Therapists assume a "portentous, brooding, and grave manner" (p. 208) to "raise parental anxiety and concern" (p. 47) and use strong language to summarize the patient's plight:
"This dreadful illness [has] clawed its way back. In fact, it has overtaken your daughter's life completely, so much so that she is dying unless we can succeed in nourishing her back to health."
(Lock et al., 2001, p. 52)

Why does the construct of the "Anorexic Self" appeal to patients with AN?

- for some of the same reasons:
 - she *does* feel different (and generally worse)
 - it is reassuring to know that it was not her Real Self who threw a tray of food, depleted the family savings, or dropped out of college - and it is a relief to be absolved of blame by others
 - the construct seems to explain and dignify the difficulty of change
- for very *different* reasons as well ...
 - it can offer a sympathetic cover story for reluctance to give up AN
 - it can allow the individual to gain approval through changing her stated allegiance without modifying her symptomatic behavior
 - it can give her a reason to fail at the hard work of recovery: she did her very best, but the outcome was beyond her control

If the Anorexic Self "will use every trick, every gambit ... and is always conniving methods for mayhem" (Claude-Pierre, 1997, p. 113) - clinicians who use externalizing should stay alert to the mayhem-making potential of their own metaphor. In effect, the construct can be co-opted and misused by the Anorexic Self Herself.

Evaluating the merits of externalizing

- key questions:
 - does it help more patients recover?
 - does it shorten time to recovery?
 - does it make recovery more complete?
 - does it cause any harm?
- no data-based answers are currently available - and none will be forthcoming any time soon
 - comparisons between modalities that do/do not externalize are uninformative (too many variables differ)
 - only dismantling research can yield clear answers
 - contribution of a single technique to overall outcome is a low-ranking research priority
 - in the absence of empirical evidence, evaluations of the strategy must be based on:
 - clinical observation
 - critical thinking

Potential problems with externalizing in the treatment of AN

(Reminder: These concerns do not apply equally - or sometimes at all - to every use of the device)

The problem of reification: Do we really want to give the Anorexic Self a life of its own?

- the cautionary tale of Dissociative Identity Disorder:
 - well-intentioned therapists took a phenomenon that was partly true and made it more so by affirming its reality - with serious iatrogenic consequences
 - some patients ended up with dozens of named identities that varied by sex, age, and even species
- extreme depictions of the Anorexic Self and the Real Self can sound like circumscribed cases of DID:
 - usually just two identities, but often described in (lurid) detail, cross-gendered, distributed across various species - and sometimes literally “called by name” (e.g., Rex, Ana, the Alien):

“I am brought back to reality [?] and find myself staring at Rex. He is tapping his ugly, long, controlling fingers on the table ... [Karen Carpenter was killed] at the hands of somebody like Rex, and I fear that Rex intends to do the same to me.” (Patient quoted in Lemberg, 1999, pp. 152-153)

“[One patient came to see anorexia] as a skeleton with a knife, little red eyes, and a black cape, like the devil.” (Maisel et al., 2004, p. 61)

“You can tell when he [i.e., Anorexia] comes out to play ... I say it’s a ‘he’ because you know a woman would never do that, so it’s got to be a ‘he.’” (Mother quoted in Lock et al., 2001, pp. 157-158)

- risks of reification:
 - names can shape our views of the disorder
 - when we call Anorexia the “Alien,” we are particularly likely to focus on the ways in which the individual has *changed* - but may be less attentive to *continuities* in her thoughts, values, and concerns
 - when we call Anorexia the “Devil,” we may not recognize the *positive* traits it also expresses and requires
 - names can shape the disorder itself
 - patients may begin enacting AN in ways that *heighten* its resemblance to the character sketch we provide

The problem of dichotomous thinking: Sick/Healthy, Black/White, Wolf/Lamb

- dualism is emphasized in some externalizing models; e.g.:
 “The conflict between these two antagonists [anorexia and anti-anorexia] mirrors those between the grand themes of Western civilization: life versus death, good versus evil, freedom versus tyranny.” (Maisel et al., 2004, p. 185)
- dichotomous thinking is already a prominent feature of individuals with AN:
 - fat/thin
 - worthless/special
 - tainted/pure
- seeing in black and white is not a helpful form of “seeing the world through our patients’ eyes”

The problem of idealizing the “Real” Self: “My daughter doesn’t have a selfish bone in her body”

- some models exaggerate the *virtues* of the patient herself, in contrast to the villainy of AN
 - according to Claude-Pierre (1997), the Real Self of an individual with AN is:
 - an “old soul”
 - an “altruistic angel”
 - who “has never done an unkind thing in [her] life”
- idealized depictions of the “Real Self” can mean real trouble for the real patient:
 - such descriptions *cannot* be true (“has *never* done an unkind thing in her life???”)
 - if the “Real Self” is expected to live up to these daunting standards, it is easy to see why she might cling to the Anorexic Alternative
 - troubling stereotypes of passive (female) victims seized by a powerful (and often male) oppressor; e.g.:
 “Here we go again, anorexia! So you’ve sneaked into the life of yet another innocent young girl ... You vampire, anorexia, haven’t you taken enough already? Aren’t you satisfied with the stream of young girls you’ve preyed upon?” (Letter from therapist to patient, Maisel et al., 2004, pp. 160-161)
 - intimation that any undesirable act, impulse, or idea “*can’t* be you” because it “just isn’t nice”
 - problem of separate bookkeeping by the Separate Selves:
 - motivation for change is created when people perceive *discrepancy* between their present actions and important personal goals or values (Miller & Rollnick, 2002)
 - if all good intentions are credited to the patient’s account while all symptomatic behavior goes on the books of Anorexia - there are no discrepancies to reconcile
- some models disavow (or narrow) this kind of stereotyping:
 - e.g., Costin (1997) stresses the importance of reintegrating “separate selves”
 - e.g., Lock et al. (2001) distinguish the self-destructive patterns of AN from developmentally desirable rebellion in other domains

The problem of demonizing the Anorexic Self:

“The first time I saw anorexia without its mask ... I was staring at a hideous monster.” (Patient quoted in Maisel et al., 2004, p. 91)

- risk of (inadvertently) demonizing the *patient*:

- evidence indicates that AN is closely linked to stable traits:

- if AN is a “hideous monster,” what about the individual in whom it emerged?

- a number of these stable traits are *positive* (when put to another purpose):

- the “Anorexic Self” is:

- idealistic as well as egocentric

- persistent as well as stubborn

- determined as well as devious

- if all “anorexic” features are externalized, the Real Self will be unrecognizable - and in some ways *diminished*

- accounts from recovered patients describe the *use* of such traits to overcome AN; e.g.:

“I decided there and then to use the self-discipline I knew I had to focus on getting better. I had been channeling this discipline into my diet and training. I decided to use it more positively and to get myself well.” (Patient quoted in Shelley, 1997, p. 57)

- risk of overemphasizing *verbal* expressions of alienation from AN

- “Hate Mail” is a common genre in some models; e.g.:

“I hate you! I’m angry at you, Anorexia! God, I hope you die and go to hell because that’s where you belong! You hurt me! You tricked me! You lied to me! Fuck you! ... God, I hate you!” (Patient in Maisel et al., 2004, p. 53)

“You are such a sick fucking liar ... [You are] absolute and total evil ... Get the fuck out of my life and leave me alone! In absolute anger and hatred of you, anorexia, Margaret” (Maisel et al., 2004, p. 158)

“I hate you so fucking much. ... I am God’s child and have no need of you ... You can go straight back to hell where you started. I want you to die, you evil, lying, deceitful, disgusting little bitch.” (Journal entry, Smith, 1998, pp. 125-126)

- concerns about “Hate Mail”:

- fine line between hate and love

- formulaic and melodramatic

- expressed attitudes belie ambivalence and encourage hypocrisy: most individuals with AN do *not* “purely hate” their disorder

- passive wish to be *rid* of AN (“I hope you die and go to hell,” “I want you to die,” “get out of my life and leave me alone”) vs. action plan for *moving away* from AN

- getting stuck in the metaphor: both therapist and patient may welcome the sense that “something has *happened*,” despite the persistent absence of behavioral change

The problem of imposed reality: “You *do* not want what you *should* not want”

- externalizing can be used to suggest that patients *don't* actually think, feel, or want what they *say* they do; e.g.:
“I know she doesn't really *mean* any of those things - it's just the Anorexia talking” (Mother of a patient)
- our professions have unflattering terms for reality-bending of this kind:
 - we call it *denial* or *repression* (when people do it to themselves)
 - we call it *invalidation* (when people do it to others)
- insisting that people do *not* think/feel what they *say* they think/feel is:
 - dismissive
 - presumptuous
 - frequently incorrect

The problem of excluded reality: “That's just Anorexia talking, and I am *not* going to listen to it!”

- differences across externalizing models:
 - some use the device to help patients *express* their private experience
 - others use it as a rationale for *not listening*: If the Anorexic Voice is not the patient's own, we are not interrupting *her* when we cut off its conversation
- discouraging the expression of “anorexic” thoughts and feelings is:
 - disrespectful
 - strategically imprudent
People are more likely to consider other perspectives when they believe that their own has been acknowledged, respected, and understood.

The problem of disallowing desire for symptoms:

“[Therapists try to make me] fit in the box that says self-starving equals self-hate. They could not be more wrong ... People are afraid of the truth: we prefer ourselves this way ... Why aspire to be less? Why assimilate?” (Grant, 1995, pp. 1-2)

- the ED field has a long history of disallowing pleasure/pride in symptoms (Bemis, 1983):
“A [patient's] statement that she feels good, even elated, about weight loss may reflect what she actually feels, although it may be difficult for therapists to feel empathy. More likely, they experience disbelief.” (Bruch, 1988, pp. 11-12)

Examples from patients:

“I was, literally and metaphorically, in perfect shape ... I was so superior that I considered myself to be virtually beyond criticism.” (MacLeod, 1982, p. 70)

“For me - this is really sick - [anorexia] is like winning the Nobel Prize or something. It's like you get a kingdom or become a goddess.” (Patient quoted in Way, 1993, p. 69)

- differences across externalizing models:
 - some use the construct to discuss pleasure/pride *covertly*
One more advantage to an imaginary playmate: “*He* feels that, not me”
 - others use it to dispute the authenticity of such experiences
- it would be nice if clinicians could learn to cope with these phenomena directly ...

The problem of neglected variables: What about the *Starving Self*?

- one fact that is often downplayed: the Anorexic Self and the Real Self are both victims of semi-starvation

Example from the Minnesota Semi-Starvation Study (Keys et al., 1950):

“In the control period we had before us a pleasant, cheerful, active young man, full of initiative, cooperative and sociable, highly altruistic, sensitive to the world’s social problems ... Twenty-four weeks later there remains only the shadow of Don’s former self. Weak and edematous, lacking physical endurance and mental initiative, grouchy and self-centered, without interest in female companionship, he was a childish slave of food.” (Brozek, 1953, pp. 117-118)

Apparently, Don’s Real Self was overthrown by an Alien Self - which turned up and took over as soon as he ate too little food and lost too much weight.

- given a forced choice between the terms Anorexic Self and Starving Self - I’d recommend the latter:
 - makes a better marker of the striking changes we see
 - references a set of behaviors/consequences and specifies how to change them
 - summarizes what *can’t* be (directly) controlled: the hard-wired effects of semi-starvation in someone who continues to semi-starve
 - avoids glamorizing AN: many patients *like* to possess an “Anorexic Self” but reject a Starved identity
 - prevents misattribution of semi-starvation effects to the psychopathology of AN
- of course there is more to AN than the Starving Self

The Starving Self cannot explain:

- why individuals begin to starve
- why they continue to starve
- why they may well return to starving after they have been weight-restored

But what follows automatically from a *decision* to starve (for whatever reason) explains much of the rest (Vitousek et al., 2004, 2005):

To reach and sustain a BMI of 15, one *needs* to:

- cultivate black/white thinking
- learn to see food as “evil” and “dangerous”
- develop rigid rules and set up potent self-imposed contingencies
- exaggerate the risk of slight deviations
- invest all choices with moral significance
- resist outside interference

When we combine the job requirements of severe caloric restriction with the hard-wired effects of starvation - we don’t need an external entity to account for most of what we observe in patients with AN.

The question of responsibility:

“I liked sitting back in my chair ... thinking: This is beyond my control. The mind lifts its hands from the wheel.” (Hornbacher, 1998, p. 131)

- across models, blame-reduction is most often cited as a rationale for externalizing AN
 - unfortunately, absolution on the grounds of diminished responsibility is a mixed blessing
 - to avoid *culpability*, we give responsibility too wide a berth

- in the treatment of other disorders, clinicians build in *additional* assumptions to reduce these risks:

Externalizing in the substance abuse vs. ED fields:

- 12-step programs:
 - posit a “separate self” (e.g., “my inner addict”)
 - stress powerlessness
- 12-step programs *also* emphasize:
 - “searching and fearless moral inventory”
 - responsibility to others
 - making amends

In the substance abuse field:

- “Hate Mail to the Alcoholic Self” is *not* a popular genre - we seldom see parallel examples:
“I hate you so fucking much. ... I am God’s child and have no need of you ... You can go straight back to hell where you started. I want you to die, you evil, lying, deceitful, disgusting bastard.”
- *a still-drinking alcoholic*
- therapists do not encourage drunken diatribes against Devil Drink ... such sentiments are taken seriously only when spoken by the *sober*
- the metaphor of the Alcoholic Self appears within the context of a relentless focus on *behavior*
- forfeiture of personal responsibility is a steep price to pay for empathy from clinicians and family members
- AN can be seen both accurately *and* compassionately; symptoms need not be construed as the “fault” of *either* Self

The question of agency: “Hey, I worked *hard* to be anorexic”

- AN is an unusually *effortful* disorder:

“Developing the anorexic state is not a process that takes place suddenly and automatically; it demands active and alert attention from its victims, every hour. [Anorexia] is not just a habit they cannot break; to maintain it requires suffering and continuous hard work.” (Bruch, 1978, p. 74)

“You don’t just *get* [anorexia] the way you just *get* a cold; you take it into your head, consider it as an idea first, play with the behaviors awhile, see if they take root ... It was not that I *thought* I wanted to be sick ... I was actively doing all that I could to be sick.” (Hornbacher, 1998, pp. 69, 124)

- some externalizing models *twice* deny agency:
 - another entity *caused* AN
 - a third party must *defeat* AN (with the patient’s assistance)

Examples:

“We can do this. Anorexia is very frightened of us ... He will never win with us here.”
(Claude-Pierre, 1997, p. 136)

Excerpts from patients’ journals, in Claude-Pierre (1997):

“Peggy won’t lie to you ... Trust Peggy. She doesn’t lie ... Trust Peggy.”

“I can’t do it - I don’t have to [do it] ... I just have to trust Montreux and let others do it ... I am being good by trusting and complying. When I get through the program I will like myself. Liking myself is part of the program.”

- there are a number of good reasons to *emphasize* agency in the treatment of AN:
 - underscore the hard work required:
 - to build an Anorexic Self
 - to dismantle an Anorexic Self
 - promote self-efficacy and pride in recovery
 - tell the truth

The question of truth: “Do therapists really *believe* this stuff, or do they just want *us* to?” (Patient with AN, on the topic of externalizing)

- a quick reminder: There is no such thing as an Anorexic Self
- one of the worst things about AN is the need for deception (of oneself as well as others); our patients should not be asked to take up any *new* distortions as a premise for recovery

The question of acceptance: Only one Self per person - with mixed motives, thoughts, and feelings

- the notion of “Separate Selves” is peculiarly out of step with trends in psychotherapy
 - across modalities, there is increasing recognition that:
 - Avoidance* is a frequent cause of distress and disordered behavior
 - Acceptance* is an important part of the solution
 - growing emphasis on “avoiding avoidance” and fostering acceptance is evident in:
 - mindfulness meditation
 - acceptance-based exposure
 - elimination of “safety signals”
 - externalizing can represent an *avoidance* tactic for patients, parents, and therapists:
 - undesirable elements must be split off or suppressed:
 - “That can’t be you” (dissociation)
 - “You don’t really feel that” (denial)
 - “We’re not going to listen to the Anorexic Voice” (suppression of experience)
 - such tactics are more closely associated with the production of psychopathology than its resolution
 - some *real* dilemmas for an individual with AN:
 - she wants her disorder - *and* she wants other things that are incompatible with keeping it
 - she wants her disorder - *and* she suffers terribly from its consequences
- Our job is to clarify these dilemmas, not to obscure them - and it *matters* how they are framed:
- reflecting ambivalence: “In some ways you want ... and yet you also want ...”
 - externalizing ambivalence: “The Anorexic Self wants ... but your Real Self wants ...”

Summarizing the “Anorexic Self”

- the Anorexic Self: an apt and efficient metaphor for our *own* difficulties with this disorder
The Anorexic Self is:
 - alien ... because we don't understand AN
 - powerful ... because we are often ineffective in resolving AN
 - evil ... because we are frustrated, angered, and saddened by the effects of AN
 - conniving ... because we can't accept patients' own attachment to AN
- the *economy* and *simplicity* of the metaphor may account for much of its appeal:
 - it is easily remembered and readily disseminated
 - it seems to resolve many of the vexing problems faced in the treatment of AN
 - it is (often) appreciated by all parties
- just as we tell our patients, however - it is hazardous to put too many eggs in one basket:
 - *simplicity* is sometimes achieved through *distortion*
 - the *economy* will be *false* if we don't count up *costs* as well as benefits
- clinicians who consider using the device should attend to *dimensions* of potential value and potential risk
 - risks may *increase* when:
 - therapists permit or encourage patients/parents to confuse the metaphor with reality
 - therapists begin to do the same
 - extreme language is used to typify Selves, with reference to *either*:
 - the absolute evil/power of the Anorexic Self
 - the absolute purity/passivity of the Real Self
 - positive associations to AN are disallowed
 - disaffection from the Anorexic Self substitutes for changes in anorexic behavior
 - risks should be *mitigated* when all parties:
 - recognize that they are adopting a metaphor
 - avoid histrionics and typecasting
 - work toward acceptance of mixed motives, thoughts, and feelings as aspects of a complex (but single) Self
 - remember the importance of behavioral change (despite persistent ambivalence)
- another key question about externalizing:
 - does it work?
 - does it work at an acceptable cost?
 - *do we really need it?*
- every admirable goal we try to accomplish through the “Anorexic Self” can be achieved without Her intervention
There are *alternative* ways to:
 - describe the disorder
 - develop understanding in parents
 - sustain empathy in therapists
 - build collaboration
 - diminish blame
 - disinhibit disclosure
 - alienate patients from symptoms(e.g., Geller et al., 2001; Vitousek et al., 1998)

Some of these require more *radical* changes in our views of this disorder and the people who acquire it
... but perhaps such changes are long overdue

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