Eclectic Therapy for Dual Diagnosis: A Case Study

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Abstract

This paper discusses the case of Helektra, a 28 year old female who was diagnosed with bulimia nervosa and borderline personality disorder using DSM-IV diagnostic criteria. The patient had referred herself to a state-run service in Athens, Greece. Therapy lasted for two and a half years. The patient’s therapeutic schedule included an integrated therapy model which was based on Fairburn’s diary (Fairburn, 1995, 2008) and on psychodynamic psychotherapy for personality disorders (McWilliams, 1994; Roberts, 1997). The findings of this case study are supportive of the benefits that have been associated in the psychological literature with the integration and eclectism of psychotherapeutic models.

Keywords: bulimia nervosa, BPD, dual diagnosis, counselling psychology

Case Context and Method

Clinical practice has shown that every psychotherapeutic model has distinctive ways in which it achieves its aims and different models are appropriate for use with different patient needs. Additionally, as patients' needs evolve during therapy they require the use of knowledge and skills from different psychotherapeutic approaches. This is increasingly recognised in counselling psychology (e.g., O’Hara, 2012; Scott & Hanley, 2012; Ward, Hogan, & Menns, 2011). Taking into consideration that therapy for eating disorders is considered to be very challenging (National Institute for Health and Care Excellence guidelines 1.3.4.: Service Interventions for Bulimia Nervosa) (National Institute for Health and Care Excellence, 2004) and that complex cases such as those with a dual diagnosis of eating disorders and borderline personality disorder often require a pluralistic approach, the integration of therapeutic models, is of particular benefit to patients with such complex needs.

Rationale for Choosing the Client

Helektra, the patient that I have selected for this case study is an example of a complex case that required the use of an integration of therapeutic approaches. Diagnosis identified bulimia nervosa and borderline personality disorder with acute suicidal ideation. This case is additionally interesting due to the fact that therapy was mediated by cultural factors as these operate in Greece.
Clinical Setting: Theoretical Orientation of the 18 Ano Unit

The 18 Ano Unit, in Athens, is a state-run service which offers free therapy both to self-referred clients and to clients who have been referred by other health-care professionals. The theoretical orientation of the Unit is reasonably inclusive and therapists are free to use the therapeutic models that they deem appropriate for their clients. Nevertheless, the main therapeutic interventions used are based on cognitive models and particularly on Fairburn’s diet diary model. Therapy is provided to national standards and it is accompanied by clinical supervision on a regular basis.

Selection of Therapeutic Approach

Counselling psychology has embraced the challenge of integrating therapeutic models. A way of achieving this objective is for counselling psychologists to include CBT and psychodynamic interventions (Parpottas, 2012; Rabinovich & Kacen, 2009) in their practice. The inclusion of these two approaches was deemed appropriate for the client case presented here on the basis of the nature of the material that the client brought to therapy.

It was decided that Helektra’s clinical presentation called for the use of an appropriate cognitive model such as Fairburn’s diary (Fairburn, 1995, 2008) in combination with psychodynamic psychotherapy (McWilliams, 1994; Roberts, 1997) for borderline personality disorders. A cognitive approach could help with the management of the client’s eating disorder. The psychoanalytic perspective is recognised for its ability to encourage the expression of patient feelings and this function makes this well-regarded therapeutic approach appropriate for use with the diagnostic category of borderline personality disorder (Arthur, 2000). Moreover, in recognition of the psychotherapeutic importance of the therapist-client relationship, issues of transference and counter-transference can be explored through the psychoanalytic approach.

In addition, the therapeutic team of the Unit takes into consideration any material that patients bring to their therapy (such as drawings, various kinds of text, objects etc.). The fact that Helektra had brought material like poems she had written and her dream content to her intake interview indicated at first that Helektra would potentially respond well to the psychodynamic approach. On the basis of this it was thought that the patient in this case study would benefit from the inclusion of the psychodynamic approach in her therapeutic regime. To achieve this, it was thought necessary to offer up to two further appointments to Helektra when required. I was appointed Helektra’s therapist and I started my therapeutic work with Helektra under the supervision of a senior psychoanalyst.

It is worth noting that the clinical team had suggested the use of Dialectical Behaviour Therapy (DBT) (Fonagy, 2007) as an appropriate therapeutic approach for use with this client. Unfortunately, this option could not be taken as there was no suitably trained professional in DBT in the clinical team of the Unit.

Ethical Considerations

Confidentiality and patient anonymity are standard practices among the Unit’s staff members Patients ordinarily sign a therapeutic contract and a separate consent form which allows Unit therapists, under certain conditions, to use anonymised material from their therapeutic work with Unit service users for publication purposes. Helektra had signed such a consent form. Permission to publish this paper was granted by the 18 Ano Eating Disorders Unit of the Department of Addictions, Attica Psychiatric Hospital, Athens, Greece. Additionally, in order to protect confidentiality and the anonymity of the patient in this paper, I have used a pseudonym, and I have omitted or amended details or facts of the patient’s life that could potentially reveal the patient’s identity.
Theoretical Basis of the Therapeutic Work

Bulimia is characterised by an immense concern about body weight and shape. The main features of bulimia nervosa are binge eating (eating excessive amounts of food) and inappropriate compensatory behaviour (purging, vomiting) in order to avoid gaining weight. Many researches confirm that CBT is very effective for bulimia (Grave, 2005). CBT has been shown to be the most effective technique with regards to food normalization and to non-relapsing attitudes (Spangler, 1999). However, it is not certain whether CBT addresses all the therapeutic needs of bulimic patients (Wilson, 1999) and this leaves space for improvements (Wilson, Grilo, & Vitousek, 2007). More specifically, there is consensus that there is a need for improvements in the use of CBT with patients who have complex needs or severe psychopathology as these patients do not appear to be responding to CBT. One such solution would be to use CBT in combination with other therapeutic approaches.

There is sufficient evidence that, generally, comorbidity in eating disorders is associated with personality disorders (Marañon, Echeburúa, & Grijalvo, 2004) and, in particular, with borderline personality disorder (BPD) (Sansone, Fine, Seuferer, & Bovenzi, 1989). With regards to bulimic patients, there seems to be no significant difference in the effectiveness of therapy for those patients with or without BPD comorbidity (Zanarini, Reichman, Frankenburg, Reich, & Fitzmaurice, 2010). Nevertheless, there is consistent evidence that patients diagnosed with bulimia and BPD suffer more intense disturbances in their eating behaviours (Wonderlich & Swift, 1990) and, additionally, their prognosis is poor (Wonderlich, Myers, Norton, & Crosby, 2002). Overall, research in this area has shown that the severity of personality disorders which are concurrent with bulimia affects the overall psychopathological profile of these patients (Zeeck et al., 2007). Moreover, BPD personality traits (e.g., self-harm, impulsivity, emotional fragility especially in rejection, promiscuous sexual behaviour etc.) seem to additionally affect therapy effectiveness in eating disorders since BPD patients are inclined to be more impulsive and more highly sensitive to rejection (Selby, Ward, Joiner, & Thomas, 2010). There is evidence (Selby et al., 2010) that impulsivity and rejection sensitivity are related to the mechanism of negative emotional affect which is subsequently related to dysregulated eating behaviour in a process of alleviation of negative emotions. This indicates that eating disorders are psychopathologically complex and this complexity affects the therapeutic process and the therapeutic outcome (Vitousek & Stumpf, 2004). On the basis of this, it can be argued that therapy for complex cases could benefit from the use of pluralistic approaches, such as integration and eclecticism, as these could address different issues with the same patient, in the same session or in the same therapeutic regime.

Eating disorders are a form of self-injury (Sansone & Levitt, 2004; Sansone & Sansone, 2007). Evidence in psychoanalytic bibliography suggests that self-harm and excessive disturbances in the perception of body image in BPD are associated with childhood traumas (Watson, Chilton, Fairchild, & Whewell, 2006). Psychoanalytic psychotherapy targets the client’s early stages in life, when the dysfunctional parental and environmental conditions contributed to the formation of a personality disorder (Korner, Gervil, Meares, & Stevenson 2008). Psychoanalytic psychotherapy enables the patient to make subtle and gradual improvements in their condition. This is important considering that the emotional insecurity and the mood swings which are prevalent in BPD make it difficult for more marked improvements to be achieved in a reasonable period of time.

Furthermore, BPD is considered “notoriously difficult to treat” (Levy et al., 2006, p. 483) owing to its complexity and to the patient’s unresponsiveness and aggressiveness. This adds to the difficulty in achieving a positive therapeutic outcome with BPD patients. Generally, there is evidence that psychodynamically orientated psychotherapy is more effective in reducing suicidality and anger in BPD (Aaltonen, Alanen, Keinänen, & Räkköläinen,
Considering the complexity inherent in eating disorders and the recognised individual differences in responsiveness to specific therapeutic approaches it would be reasonable to suggest that therapeutic integration would be an appropriate and effective way to achieve a positive therapeutic outcome in patients with complex needs.

A perusal of the literature indicates that evidence in the use of eclectic or integrative therapy in eating disorders is limited. Nevertheless, issues of severe and complicated psychopathology make it imperative to explore the potential benefits of pluralistic (eclectic or integrative) therapeutic interventions. Cooper and McLeod (2010) claim that the exploration of all potentialities in psychotherapy is likely to lead to an improvement in the effectiveness of therapy. The expected outcome of the integration of therapeutic models has been eloquently described as the Dodo Bird in Alice in Wonderland which declares “Everyone has won and so all must have prizes”, (Shorrock, 2012, p. 26).

Case Study

Summary of Therapeutic Progress

Helektra’s therapy proved to be long term and it lasted for two and a half years during which time the patient attended psychotherapy sessions, on average, once a week. Long-term psychotherapy was deemed necessary owing to the severity of the patient’s case. Approval to provide psychotherapy to this client for an extended period of time was granted by my clinical supervisor and by the Hospital authorities. Initially, therapy concentrated on symptom relief for bulimia and for suicidal ideation. In later stages, therapy became more in depth and Helektra was able to explore deeper traumatic issues. Overall, I managed to develop a good therapeutic relationship with Helektra. Additionally, there was a gain of experience for me as a counselling psychologist as I was able to use different psychotherapeutic approaches with the same patient and this offered me the opportunity to explore the therapeutic potential of eclectic therapy.

As part of my work with Helektra, I kept records from each session along with any kind of notes, poems and drawings that the patient kept bringing to her therapy. Additionally, I had the opportunity to cooperate with the art therapist and the occupational therapist of the Unit and my cooperation with these therapists enriched my understanding of Helektra’s situation. Furthermore, I was in contact over Helektra’s therapy with the psychiatrist of the Unit whom Helektra kept seeing once a month for the medication she was on.

Presentation

Helektra’s presentation was that of what would be considered in Greece to be an “elegant woman”. It looked like she cared for her appearance. She was slim and she was well-dressed when she came to her therapy sessions. She lived alone in Athens where she had moved from provincial Greece to take up an undergraduate course in Architecture. She did not work and she was fully financially supported by her father.

Her bulimic behaviour commenced at the age of seventeen. She suggested that her bulimic episodes and vomiting occurred twice a day on average. At the same time, she also made use of psychotropic substances such as cannabis, cocaine and MD. The use of drugs lasted for about six years. On the previous year, the patient had stopped using drugs but she had started drinking alcohol. Additionally, the patient reported impulsive sexual behaviour. She used the expression “destructive liaison” to describe her sexual practices which appeared to be quite risky. At the time she referred herself to the Unit she was in a relationship which was characterised by emotional
turmoil and where there was no sexual contact between partners. In recent years, the patient experienced severe suicidal ideation and she made three suicide attempts. In the last two years she started visiting the priest of her local church from whom she sought solace and spiritual guidance.

**Goals**

At intake Helektra’s stated goals were to stop her bulimic behaviour and to receive support that would help her complete the write-up of her dissertation. She appeared to be desperate for help and this was evident when she claimed to have used another Eating Disorders Service where she was advised to seek further help at the 18 Ano Unit.

**Assessment of the Patient’s Goals** — Helektra defined her difficulties in the initial session as:

1. I cannot bear this habit, I need help to stop bulimic episodes.
2. I desperately need help to concentrate on my dissertation.
3. I feel completely alone, I struggle with my social relationships.
4. I do not have any friends.

**Therapeutic Goals** — At the end of her initial assessment, the therapeutic goals which were agreed upon with Helektra were:

1. At the first stage of therapy: To keep a diary of her eating habits.
2. Take precautions not to fight with her boyfriend. Leave the place when she felt that an argument was coming up.

After this stage was stabilized the goals were agreed as:

1. To quit the bulimic behaviour.
2. To stop self-harming.
3. To concentrate on her dissertation.
4. To feel more confident in her relationships and more aware of her feelings and to feel comfortable enough to share her feelings with important others.
5. To feel more confident in making decisions about her life.

**Patient’s Protective Factors**

Helektra was very intelligent. She was capable of deep thinking and she seemed able to understand psychological concepts. She also demonstrated a strong will to find ways to understand herself better. Additionally, she was extremely sensitive and kind-hearted, very well-informed about topical social issues, very keen to be involved in charity and to volunteer in social care.

She was talented in painting, she was very well-read, and she could draw insightful pictures or write poems being inspired from her own life experiences. She also enjoyed listening to classical music and she played the piano. Furthermore, she appeared to have a good sense of humour.

**Patient’s History**

Helektra was raised in a small town. She had one brother with whom she maintained a warm relationship. Her father was the main breadwinner and he worked hard to support the whole family. The patient described her
father as a man with a terrible temper which he needed to control by taking medication. She additionally described him as someone with an impulsive and violent behaviour who also drank heavily. At a later stage, the patient claimed that her father had a mental illness which was a well-kept family secret. The mother was ten years older than the father. She was a homemaker and she took care of everyone including her mother-in-law who lived with the family.

Helektra was the younger of two children in the family. She claimed that the relationship with her father was contradictory (cf. Wade, Bulik, & Kendler, 2001, for a discussion of the connection between bulimia and the quality of parent-child relationship). Her father always told her that he wanted Helektra and himself to be friends and to talk to him about her relationships with boys. On the other hand he would beat her for disobeying him if she went against his wishes. She described him as very demanding especially about anything related to his children’s education. Later she said that he showed off to other parents as the perfect parent. She also claimed that he pressed on her for excellent school results so he could boast to other parents and eventually run for chairman of her school’s parents committee. It would be appropriate to assert that it is a wide-spread cultural characteristic that school performance is considered to reflect good parenting practices in Greece. Greek parents ordinarily put pressure on their children to do well at school as this has a direct effect on their perception by others as good parents and worthy members of the society. In the latter part of her therapy Helektra realized that her father wanted to appear as a good and caring father to hide his own mental health problems.

Ever since her early childhood Helektra recalled her father being very cruel to both children. She claimed that there had been many occasions where she froze her feelings when her father screamed at her. Later on in her therapy she claimed to have realized that her mother was terrified of him, too, and that she suffered silently unable to react to his violence and to protect her children.

**Treatment**

There were four stages in the patient’s personal therapy. In the first stage, (duration: six months), therapy was mostly based on cognitive approaches such as Fairburn’s diet diary reports and psychoeducation on how to enrich her diet report and to cease the bulimic and vomiting behaviour. In the second stage, (duration: twelve months), there was a combination of the use of a cognitive approach, a continued use of the diet diary reports and psychoanalytic interpretations of the patient’s dreams. In the third stage (duration: six months), the therapeutic procedure was mostly focused on the existential issues which arose whilst the bulimic behaviour started to dissipate. In the fourth stage (duration: six months), there was re-decision and, ultimately, discharge.

**First Stage** — Helektra was seen by a psychiatrist who made an assessment of her situation and issued her diagnosis. The psychiatrist also prescribed medication to Helektra. This was deemed necessary as Helektra was experiencing severe psychological difficulties which affected her mood considerably. She had violent arguments in her relationship, she had an unstable social life and she exhibited signs of acute suicidal ideation. According to National Institute for Health and Care Excellence BPD Guidelines (National Institute for Health and Care Excellence, 2009) priority should be given to suicidal ideations whilst the patient has to be referred to a specialist centre. It should be noted that Helektra was seen by a specialist Unit which is part of a state psychiatric hospital and which is the only psychiatric Unit in the Greek National Health Service that specialises in eating disorders that are accompanied by comorbidity. Helektra saw the Unit psychiatrist for six sessions. Following this, she was referred for psychotherapy and I was appointed her therapist.
In the next five sessions Helektra was punctual for her appointments. However, she appeared hesitant or unwilling to discuss her issues. On most occasions she started crying before talking or she claimed to have shortness of breath that made her unable to stay until the end of the session. This seemed to indicate to me that Helektra was testing my acceptance and sympathy and that this was useful to her in preparing the ground for a therapeutic contract with me. I had to be clear setting the rules and conditions of the Unit but very understanding to her personal story and individual needs. My approach was confirmed in clinical supervision to have been an appropriate response to the patient’s needs.

In this stage the “key moment” was when Helektra once arrived late for her appointment. She said that she felt tired and desperate because every close person to her never showed understanding towards the disappointment and the pressure she has always felt and she started crying again. I asked her if she feared that this would happen with me too. She nodded “yes”. Then I told her that if she felt tired and reluctant to talk we could reschedule her appointment. She said she was relieved. She was never late again and she always gave me a week’s notice when she anticipated that she could not attend her next appointment.

She faithfully kept her diet diary. In the first six months her bulimic episodes were reduced from two or three per day to one. She increased her ability to articulate and to discuss the reasons for the episode. At the end of the first year she had almost stopped her bulimic behaviour from occurring on a daily basis but she still occasionally continued to have bulimic episodes. In this phase, her diet diary showed great dietary improvement. She had started eating foods that she previously considered to be forbidden and she could join her family or boyfriend for food without thinking of vomiting after eating.

In this stage Helektra had a determinative dream for the process of her therapy. She dreamed of a ruined house without doors and windows which had a big cistern which was visible from any angle. She realized that she could not hide behind the doors of the toilet and anybody could watch her vomiting. During the session she made links between the house in her dream and her bulimic behaviour and she said that she thought her condition was like the ruined house in her dream. At this point I kept my intervention to a minimum, offering Helektra the chance to express how she felt. This was consistent with my clinical supervisor’s suggestion that therapist comments and interpretations should be avoided, especially in relation to the dreams that the client was bringing to therapy. It is documented that there is a therapeutic benefit for clients when they name their emotions without distractions from the therapist (Yeomans, Clarkin, & Kernberg, 2002).

In the following sessions she talked about the need for change and self-improvement and the need to stop lying to herself about her bulimic behaviour. She also started talking more openly about her father’s violent behaviour. She connected the bulimic episodes with her father’s screams which occurred almost every time the family sat around the table for a meal. She also realized that vomiting was mostly a reaction to the feelings of discomfort with her father’s screams than a way to maintain her low weight.

**Second Stage** — In the second stage therapy concentrated on helping Helektra find a way to feel and express her feelings. There were occasional relapses of bulimic episodes. Helektra realized that stress and disappointment were a strong factor of relapsing. In this phase of therapy she was motivated to start her dissertation. There were many difficulties to deal with, especially low self-confidence and self-esteem. This phase was more narrative, she spoke about the past and cried a lot for admitting false acts she impulsively did. Using psychoanalytic psychotherapy (Masterson, 1983; Masterson & Lieberman, 2004) I listened to her carefully and explained every suggestion with caution. Helektra was very descriptive and although the whole process was exhaustive for her, most of the times,
she did not give up her effort to connect with her feelings. She also said that she was very surprised she had remembered details of the past.

**Third Stage** — In the third stage I encouraged Helektra to explore ways to handle her feelings of discomfort and to realise how to address her feelings towards others. During this stage of therapy, she could express her anger without self-harming. Furthermore, her relationship with her boyfriend had improved and the fights they had had were reduced. Personal and existential issues prevailed during the sessions and she spoke mostly about her relationship with her parents. Most of the dreams she had caused tremendous fear in her about mental illness. She linked this with her perception of her father’s mental illness. She was able to relate this experience with her fear about never being able to recover from her own psychological difficulties. She also connected her grandmother’s “difficulty” to communicate with probable signs of mental illness. Additionally, Helektra finally talked about her anger towards her mother, a matter that she had always avoided. She expressed her fear that she could never bear to be like her mother.

In this period many issues about Helektra’s sexual life preoccupied her. She had many dreams about this matter. I chose to take a supportive and non-directive approach during this stage. Helektra talked about her sado-masochistic fantasising and practices in ways that revealed feelings of guilt for having those fantasies and experiences. Under the auspices of clinical supervision, my role was to help Helektra get over her feelings of guilt and to stop her from feeling “dirty” for her sexual life. Following this stage, Helektra stopped having sex altogether. This was probably related to the religious guidance and influences which she had been under towards the end of her therapy.

**Fourth Stage** — The fourth stage was taken up by reflection. Helektra was encouraged to reflect on the initial therapeutic goals and to consider how these had been achieved. Meanwhile, it was particularly fulfilling to learn that, during this period, Helektra completed and handed in her dissertation and she also got engaged to her boyfriend. Lastly, to help Helektra prepare for her discharge, the sessions were arranged in larger time intervals, every second week. Helektra continued to take her prescribed medication and her new target was now to make herself feel well enough so as not to be in need of this medication anymore.

This new target essentially involved further therapy regarding her personality disorder. The therapeutic group, under the supervision of the scientific coordinator of the unit, reviewed the case of Helektra and decided that the intervention about her eating disorder was successful and that she could now be discharged. Furthermore, Helektra could now be referred to a specialized Unit for group therapy for her personality disorder. Group therapy would also give her the chance to improve her social skills (Campo-Redondo & Andrade, 2000) since making friends and feeling comfortable in social activities was still a difficult issue for Helektra.

**Discussion**

Overall, Helektra’s therapy was challenging but it was also extremely rewarding to see that Helektra achieved her therapeutic goals. The challenges that had emerged during Helektra’s therapy made me feel pessimistic about the course of her therapy. Helektra’s life had such complexity that it took particular skill to avoid getting involved personally in her situation. Additionally, I found that the use of two different therapeutic approaches with the same patient required skilfulness and great care. An added difficulty was the fact that the scientific literature on the use of pluralistic models, particularly in the case of eating disorders, is sparse. I was able to get around this with help from clinical supervision.
The CBT approach that I used with Helektra was shown to be very helpful in enabling the patient to manage her eating disorder. Helektra’s co-morbidity was an added difficulty in the therapeutic process. CBT-E appears to be very effective even in more complex cases of eating disorders (Murphy, Straebler, Cooper, & Fairburn, 2010) and research is needed to help explore further the advantages of this approach. As it was mentioned earlier, the patient was diagnosed with borderline personality disorder and she had emotional instability and severe impulsive behaviour. Helektra’s total financial dependence on her father forced her to tolerate his abusive behaviour and this made her relapse on occasions. Helektra’s psychological state made it difficult for her to keep up a job and when her condition later improved the financial crisis which had set in in Greece had affected job availability considerably. Hence, it was difficult for her to find employment.

Furthermore, I used the psychodynamic approach with Helektra mainly to give her an opportunity to explore the childhood issues that she brought to therapy. In addition, this approach helped analyse Helektra’s dreams as well as her poems and drawings. I was assisted in the application of the psychoanalytic approach through discussions with my clinical supervisor which helped me achieve a better understanding of the role of transference and counter-transference in the formation of trust in the therapeutic relationship. Additionally, these discussions encouraged me to identify scientific sources which explored the contribution of psychoanalytic theory in the understanding of the therapeutic relationship in counselling psychology (e.g. Laughton-Brown, 2010).

Helektra is now continuing with therapy for her personality disorder. Additionally, she has had three follow up sessions with me in the Unit since her discharge. In the first two sessions I offered Helektra support for her experiences in group therapy and I helped her reframe the difficulties that she had faced with the group. The third follow up session took place because Helektra wanted to announce to me that she was getting married.

Conclusion

In conclusion, although there are arguments against the practice of integrated and eclectic psychotherapy (Cutts, 2011), I personally found the use of two different therapeutic approaches with the same patient to be effective and I would encourage the integration of therapeutic approaches where this is deemed to be of benefit to the patient. After all, our goal as therapists, as Wheelis (2010) has suggested, is “to discover what works to alleviate our patients’ suffering” (p. 335).

Lastly, in the case of Helektra’s therapy, I managed to encourage the formation and maintenance of a good therapeutic relationship by drawing significantly on techniques from psychoanalytic theory such as the use of positive transference – counter-transference. Additionally, I achieved integration by resorting to empathy, congruence and unconditional positive regard. This was necessary in order to form a trustful therapeutic alliance.

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