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Typological features of eating disorder patients: A review of publications

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Abstract. Despite the fact that the development and course of various types of eating disorders, and therefore their treatment, largely depend on the typological characteristics of patients, this aspect has been understudied. The purpose of the study is to review the problem of providing psychological assistance to eating disorder patients with various typological features. Using methods of analysis, synthesis, and comparison, the paper emphasises the importance of typological features of eating disorder patients in providing psychotherapeutic care. Patients with certain personality traits, such as perfectionism, the need for control, and impulsivity, have been found to be prone to eating disorders, while these typological personality traits, along with many others, have been shown to help build treatment strategies for anorexia nervosa, compulsive overeating, and bulimia nervosa. The analysis showed that there are traits specific to certain eating disorders that can be reinforced in overcoming food addiction. The influence of personal characteristics on the choice of psychotherapy strategy and the possibility of forming psychotherapeutic relationships are covered. The importance of typological features of eating disorder patients in the provision of psychotherapeutic care is revealed. To enhance the effectiveness of selecting a psychotherapeutic care strategy and establishing psychotherapeutic relationships, this paper summarises the primary personal characteristics associated with different types of eating disorders. Attention is paid to typical behavioural manifestations in the presence of one of the types of eating disorders. The main prerequisites for the development of a personality prone to dependent behaviour are substantiated. The central perspective on the role of the family in the development of an eating disorder is established. The practical value of the study lies in the possibility of using the findings to expand the understanding of the typological features of patients with food addiction to provide effective psychotherapeutic care

Keywords: food addiction; anorexia nervosa; bulimia nervosa; compulsive overeating; psychotherapy

INTRODUCTION

Various types of dependent behaviours in the 21st century have emerged as major challenges for humanity, necessitating society to confront and address these issues to overcome them The spread of eating disorders among people globally is becoming very relevant. The most well-known environmental factor contributing to the development of eating disorders is the socio-cultural idealisation of thinness. The most common eating disorders include anorexia, bulimia, and compulsive overeating (Hay, 2020; Costandache *et al.*, 2023). Along with the genetic, cultural, and social prerequisites for the development of eating disorders, an important place is occupied by the psychological component of the dependent person. Eating disorders are a defining characteristic of clinical eating disorders, anorexia nervosa, bulimia nervosa, and compulsive overeating. Modern psychotherapeutic theories place the main focus on the presence of dysfunctional development and disturbances in personality structure resulting from the experience of

psychotraumatic events and disharmonious relationships with significant figures during childhood in patients with food addiction (Palmisano *et al.*, 2018; Kovács-Tóth *et al.*, 2022; Malet-Karas *et al.*, 2022).

Between 2000 and 2018, the prevalence of eating disorders in the world increased from 3.4% to 7.8% (Galmiche *et al.*, 2019). 70 million people worldwide live with eating disorders (National Eating Disorders Association, n.d.). Eating disorders have the highest mortality rate among all mental illnesses (Smink *et al.*, 2013). The vast majority (97%) of people hospitalised with an eating disorder have comorbidities. Mood disorders, such as clinical depression, are the primary conditions followed by anxiety disorders, such as obsessive-compulsive disorder, post-traumatic stress disorder, and substance use disorders. Up to half of people with eating disorders abused alcohol or illegal drugs five times more often than the general population (Claudat *et al.*, 2020). Every year, the issue of dependent personality becomes more and more relevant and requires consideration of the typological features of eating disorder patients to ensure an effective model of psychotherapeutic care. To gain a deeper understanding of these disorders, it seems crucial to shift attention from abnormal eating behaviours to more complex and subtle psychological features, especially those that arise from the patient's past experience. This characterisation is an essential prerequisite for identifying new therapeutic targets and therefore for improving recovery outcomes from these severe disorders (Esposito & Stanghellini, 2020). Recent studies and theories have moved away from understanding the etiological causes of eating disorders, instead focusing on potential maintaining factors, individual characteristics, and interpersonal support, including the response of close individuals (Fox & Whittlesea, 2017).

The purpose of the study is: to analyse the main typological features of eating disorder patients. Moreover, to examine the problems of providing psychological assistance to eating disorders patients with various typological features. Compare typical behavioural manifestations of a person in the presence of one of the types of eating disorder. To identify the impact of individual personality traits on the choice of psychotherapeutic intervention strategies and the potential for forming therapeutic relationships. To determine the main prerequisites for the development of a personality prone to dependent behaviour, and the role of the family in the development of an eating disorder.

PERSONAL MANIFESTATIONS OF A PATIENT WITH FOOD ADDICTION

Clinical observations of H. Bruch (1980) highlighted key features observed in eating disorder patients that require attention in psychotherapy, in particular, distorted perceptions and misconceptions about body size, interoception, body functions of hunger and satiety, and problems related to controlling body functions. H. Bruch also emphasised the diversity of psychological and family characteristics inherent in these disorders. Her observations and ideas remained unchanged and formed the theoretical basis of therapeutic concepts used by psychodynamically oriented and cognitive behavioural psychotherapists. Formulation of H. Bruch was influenced by a list of eating disorders and an influential cognitive analysis of P.E. Garfinkel and D.M. Gamer (1982), who identified common examples of all-or-nothing thinking in eating disorder patients. These concepts, in turn, have influenced systematic methods of cognitive behavioural psychotherapy for patients with anorexia nervosa, bulimia nervosa, and overeating developed over the past two decades.

P. E. Garfinkel and D.M. Gamer (1982) also focused on the importance of the motivational component for patient participation in treatment and recovery. These views led to the development of psychotherapeutic strategies for treating eating disorders based on transtheoretic models and strategies for increasing motivation, based on the studies of J.O. Prochaska and C.C. DiClemente (2005) and W.R. Miller and G.S. Rose (2009), whose approaches were mainly used with patients suffering from alcoholism and substance abuse. These strategies attempt to take patients out of a state that often appears pre-contemplative (denial, avoidance, minimisation), into states of contemplation in which they can acknowledge the existence of a problem, states of reflection in which they seriously consider the need for help, and states of action in which they are actually involved in treatment. Studies conducted today (Fetahi *et al.*, 2022), focus on the potential value of strategies that increase motivation at the beginning of psychotherapy for eating disorder patients. Motivational state strongly correlates with the characteristics of brain structures. People whose brains lack nutrients may be less capable of self-awareness or understanding of the situation and therefore are more likely to appear unmotivated than those whose brains receive adequate nutrition.

The main intrapsychic factors of eating disorders include: increased anxiety and a tendency to depressive reactions; distorted self-perception and misinterpretation of changes in attitudes on the part of others; a tendency to obsessive states; perfectionism (painful pursuit of perfection); unstable or exceptionally low self-esteem; sensitivity to encouragement and punishment (Keel *et al.*, 2012).

Longitudinal studies confirm the role of obsessive-compulsive disorder, neurotic states, anxiety, and negative emotional responses in the personal background of eating disorders (Loxton & Dawe, 2009).

Dissatisfaction with one's body, especially with the proportions and weight, is characterised as a dysmorphophobia - anxiety about imaginary physical deformity (Careaga *et al.*, 2016). Notably, social surroundings have a huge influence on the development of body image: the standards of beauty accepted in society, and the attitude of the family to them. Body image includes perceptual, cognitive, and emotional components, is formed based on life experience and reflects the worldview of the individual and one's psychological difficulties.

Perfectionism is a key characteristic of a person suffering from food addiction. Thus, S.E. Cassin *et al.* (2019)

note that high negative emotionality, perfectionism, and a tendency to limit and control characterise restrictive-type anorexia nervosa, while high negative emotionality, perfectionism, and impulsivity are risk factors for purging-type anorexia nervosa and bulimia nervosa.

It is worth noting that impulsivity, which also includes the search for novelty and the desire for pleasure, is one of the key characteristics when explaining eating disorders in terms of addictive behaviour. Low self-esteem can lead to a variety of maladaptive behaviours, including eating disorders (Polivy & Herman, 2002).

A. Harrison *et al.* (2020) showed that people with eating disorders are more sensitive to reward and encouragement than healthy people. D. Westen and J. Harden-Fischer (2001) examined the comorbidity of eating disorders and personality disorders, and they identified three subtypes of personality that occur among food addicts: 1) high functional / perfectionist group; 2) over-controlling / avoidant group; 3) impulsive / disorganised group

The researchers note that the identified three subtypes of personality allow for a better choice of psychotherapy strategies for eating disorder patients (Westen *et al.*, 2004).

Psychoanalytically oriented psychologists utilise Operationalised Psychodynamic Diagnosis (OPD) in their study, which helps construct the psychotherapeutic process with a focus on the individual patient's characteristics, particularly the structural level of psychic organisation, the presence of psychotraumatic events, and the dominant intrapersonal conflict (Biliavska & Medynska, 2022).

Modern studies (Rohde *et al.*, 2019) systematically describe differences in aspects of personality structure by subtype of eating disorders, considering personality structure by OPD. It was described that the differences observed in the subtypes of eating disorders can be used to guide therapeutic interventions. Unified scales can be used to discuss the goals of psychological treatment in relation to the functioning of the individual with patients.

Psychoanalysis can be effective in treating eating disorders. In one comprehensive research review of psychoanalysis and eating disorders, 67 psychoanalytic studies were analysed. The review concluded that psychodynamic therapy is effective in helping patients suffering from eating disorders and personality disorders (Bemporad *et al.*, 1992). When developing a comprehensive treatment plan for eating disorders, it is important to adapt the plan to each individual. The central focus in the treatment of eating disorders involves facilitating the external expression of aggression through transference, as this supports the patient's efforts to free themselves from the experience of emotional subordination. Subsequently, it may enhance the patient's ability to express these emotions in new relational contexts (Wooldridge, 2022).

Therefore, most studies focus their attention on the personal manifestations of a patient with food dependence and concomitant factors that affect the treatment process and the establishment of psychotherapeutic contact. Deficiencies in treatment approaches have been widely documented around the world, with many proposed explanations. These range from the specific association of people who have eating disorders with low mental health literacy, eating disorders in people with problems and health professionals, and widespread stigma at all levels.

MAIN TYPES OF EATING DISORDERS

Eating behaviour encompasses the attitudes towards food and its consumption, the eating patterns under regular and stressful conditions, the orientation towards body image and activities related to its formation (Treasure *et al.*, 2020).

Eating disorder patients are concerned about food and exhibit behaviours that appear alternately compulsive and ritualistic (such as restriction) or disinhibited and impulsive (such as overeating). Anorexia nervosa is a mental disorder characterised by deliberate weight loss due to fear of obesity and belief in one's own excessive fullness, caused and / or maintained by the patient themselves through conscious refusal to eat, excessive exercise, artificially induced vomiting, and other actions, the use of appetite suppressants and diuretics (World Health Organization, 2010). Anorexia nervosa can be classified into two types: the purging type, in which individuals engage in binge eating and then resort to purging rituals, and the restrictive type, where individuals suffer from compulsive overeating but try to severely restrict their food intake and engage in excessive physical exercise.

Bulimia nervosa is an eating disorder characterised by episodic overeating. Binge eating involves consuming a significantly large amount of food within a specific time interval, which is far more than what an average person would typically eat. Nevertheless, there is no complete control over the process of eating food (Levinson *et al.*, 2021)

In bulimia, body weight can be low or normal because the individual engages in compensatory behaviours. Although they experience episodes of binge eating, they compensate by inducing vomiting or engaging in excessive exercise to burn calories. People with bulimia are almost always concerned about their condition, and may complain of somatic problems and attempt to lose weight. Very often, patients with this disorder experience a predominant feeling of shame, driven by an unconscious belief of "I am bad, I do not have the right to exist."

Compulsive overeating is an eating disorder very similar to bulimia, but in this case, there are no purging behaviours (vomiting) involved. Food is consumed without the presence of physical hunger. A characteristic feature is that such patients eat alone and rarely sit down at the family table. If parents with anorexia may notice that the child, for example, eats half an apple for dinner, patients with compulsive overeating feel ashamed, because the amount of food is often very large.

With anorexia, there is a sharp weight loss in a short period of time. This is a characteristic sign of this disease. People with anorexia almost never say that they have health problems: they are doing well, they are moving towards their goal, and they are actively reducing weight. The danger of anorexia is that there is no point, weight, at which the

patient can stop. Even with a weight of 25 kg in intensive care, the patient does not consider it necessary to eat. Anorexia may seem to be driven by an ideal of thinness on the surface; however, its "hidden daily order" is actually about rejecting femininity and adult life (Doerr-Zegers & Pelegrina-Cetran, 2020).

In general, there is a common misconception that eating disorders are a lifestyle choice. Eating disorders are indeed serious and often life-threatening conditions, characterised by severe disturbances in people's eating behaviours, thoughts, and emotions related to food.

TYPOLOGICAL FEATURES OF EATING DISORDER PATIENTS

The fear of gaining weight in eating disorders is stronger than the fear of dying. From the experience of building psychotherapeutic relationships, such patients are wary, and it is very difficult to establish trusting relationships with them. Their biggest fear – is food, and psychologists and doctors encourage patients to start eating. It is the same as asking a person with arachnophobia (fear of spiders) to hold a spider. With such patients, it is very important to conduct psychotherapy work. The nature of symptoms in anorexia nervosa and bulimia nervosa often leads patients to seek help only after they have suffered from the disorder for many years. This mainly refers to the denial of the disease by patients with anorexia nervosa, the shame and secrecy of patients with bulimia and compulsive overeating. Once treated, patients with anorexia and bulimia are reluctant to give up their ego-synth pathological desire to lose weight, which for patients with anorexia leads to significant weight loss, and for patients with bulimia fuels overeating and purging. This behaviour is largely selfish. Patients with anorexia nervosa pursue thinness not as a means, but as an end in itself. Clearly, individuals with anorexia nervosa exhibit resistance towards activities they feel compelled to do, as these behaviours serve an adaptive and organising function for them. This reluctance forms the basis of deficits in self-regulation and affective regulation since caloric restriction, binge eating, and purging often act as psychological anaesthetics, linking negative emotions and removing them from conscious awareness (Culbert *et al.*, 2015). As a result, these symptoms of eating disorders tend to develop their own lives, are self-sustaining, and often become immune to psychotherapy, psychological accessibility, and cognitive and behavioural interventions aimed at the symptoms of the disorder. Less clearly, food chaos and hunger can cause affective, cognitive, and somatic symptoms that can be difficult to distinguish from more typical primary depression. Eating disorder patients have serious trust issues in their relationship with a therapist. More often, this is due to a violation of basic trust in the world (Paris, 1997). Previous family relationships are often perceived as intrusive, controlling, or abusive. This can undermine the fragile self-perception during the formative years of future anorexia or bulimia, as these patients fear entrusting themselves to relationships that require a certain level of vulnerability and loss of control. Comorbid anxiety disorders are common in patients with anorexia and bulimia. In one of the studies (Guarda *et al.*, 2015), 60% of patients with anorexia and 57% of patients with bulimia had a comorbid anxiety disorder, most of which started before the onset of the eating disorder. Women with bulimia show higher levels of novelty cravings, impulsivity, and sociability, while women with anorexia have a much more pronounced characterological style of obsessive harm avoidance. Psychologists should be aware that an eating disorder involves significant anxiety and that it is necessary to take measures, whether pharmacotherapy or specific psychotherapeutic methods, that help the patient cope with these affects, normalising their diet and gaining weight.

Eating disorder patients have a lack of self-perception, which is usually observed in people with characteristic disorders, especially with pronounced narcissistic and borderline pathology. These include difficulties in regulating self-esteem and affect, problems with separation and a sense of healthy autonomy, and problems with impulse control. Eating disorder patients are more likely to have marginal and psychotic levels of mental organisation (Kernberg, 2018). Frequently, people with anorexia have an upper limit level of mental organisation, and people with bulimia and compulsive overeating have a lower limit level of mental organisation. The boundaries of intrapersonal conflicts are often blurred, making it challenging to diagnose the primary conflict (Fuchs, 2022). However, in general, more commonly encountered conflicts include self-esteem conflicts, identity conflicts, control and submission conflicts, and autonomy versus dependency conflicts. Based on the history, the presence of psychotraumatic circumstances during the first year of life and traumas during anal and oedipal psychosexual periods can be identified (Reich & Cierpka, 1998). These typological features in eating disorder patients lead to difficulties in psychotherapeutic relationships. These include the fear of attachment and addiction, the fear of being caught up in emotions, a strong sensitivity to rejection, and the need to please others, which creates a false self. All these features complicate the already unformed trust of patients with food addiction in psychotherapeutic relationships. These difficulties create the need for the therapist to be active, open, compassionate, but firm and set realistic goals and create an environment in which a positive alliance can develop. It is necessary to focus on analysing both the patient's past experiences and current problems. Cognitive and behavioural strategies should be used to combat the humiliation of human dignity and misconceptions about nutrition (Waller & Raykos, 2019; Agras & Bohon, 2021). This approach helps limit regression and possible psychological fragmentation.

No matter how complex and severe eating disorder patients may be, they deserve serious and close attention. As with substance abuse, the change in patients with food addiction is spiral rather than linear, with frequent fluctuations between improvement and withdrawal. Screening for personality dysfunction, both in psychosomatic patients

and those with dependencies, is considered increasingly important for treatment planning in clinical settings as it allows for identifying specific clinical pathways at an early stage (Obbarius *et al.*, 2018). However, despite the phenomenological similarity between patients with other types of addictions and patients with food addiction, there is one striking attribute difference that affects motivation in these settings. In eating disorder patients, especially anorexia, there is a clear bias that their disease can be considered an outstanding achievement. This is different from substance abuse, in which there is a protest against addiction being labelled and in no way a descriptive characteristic of the individual (Piccinni *et al.*, 2020). This qualitative difference makes the anorexia nervosa patient even more reluctant and unmotivated to change than the typical addict.

These observations suggest that under-eating itself significantly contributes to cognitive impairments and amplifies many psychopathological features characteristic of anorexia nervosa (and some patients with bulimia nervosa), including obsessive thinking, perfectionism, and other relationship-building characteristics associated with eating disorders, as well as symptoms of anxiety and depression. Many of these psychopathological features are considerably improved simply by resuming eating and improving nutrition. Accordingly, modern views claim (Collantoni *et al.*, 2019a; 2019b) that psychotherapy for anorexia nervosa and bulimia nervosa should be adapted to the patient's degree of malnutrition and cognitive function.

Problems of genetics, temperament, and development define the main theories regarding psychotherapy for eating disorders (Bulik *et al.*, 2019). Individuals developing anorexia nervosa and bulimia nervosa may be more likely than others to exhibit certain premorbid vulnerabilities, such as family tendencies towards weight and energy expenditure concerns, obsessiveness, perfectionism, and/or susceptibility to anxiety, depression, low self-esteem, and self-doubt (Ralph-Nearman *et al.*; 2019 Kroplewski *et al.*, 2019; Gruber *et al.*, 2020). In some patients, the concomitant occurrence of substance abuse problems may contribute to the initial manifestation of eating disorders (Miranda-Olivos *et al.*, 2023).

The analysis of the family environment of patients with addiction acquires considerable importance (Gorrell *et al.*, 2019; Rosania & Lock, 2020). Families of eating disorder patients show great diversity in their dynamics, and systemic problems, from normal health to extreme dysfunction. All parents with a child showing self-destructive behaviour and emotional turmoil associated with serious eating disorders are upset by these events and show various signs of distress and emotional reactions towards that child. Moreover, families with certain dysfunctional behavioural patterns make an additional contribution to the pathogenesis and support of some patient problems. Many of these dysfunctional family patterns are not specific to eating disorders but are thought to exacerbate a wide range of psychosomatic illnesses, conditions, and other mental disorders.

S. Minuchin *et al.* (2007) described certain families characterised by excessive overprotectiveness, rigidity in supporting a return to the original state, and avoidance of conflicts, resulting in a lack of permission for conflicts within these families. Other difficulties are associated with psychological, physical, and/or sexual violence, a high degree of expressed negative emotions (when one or several family members are highly critical of the patient and blame them), ridicule, and the distorted influence of competitive or narcissistic parents. Parental intrusion and lack of respect for privacy or autonomy, as well as colluding with one family member, create conditions conducive to the development of pathological behaviour in patients with eating disorders. These observations have led to the recognition that family assessment and family-oriented interventions, counselling, and/or psychotherapy can be crucial in the treatment of patients with eating disorders, especially in children, adolescents, and young adults who may still be living at home and closely connected to their families. For adults who are married or in a permanent relationship, problems like the ones described above may increase the need for family therapy.

CONCLUSIONS

The study focused on the main eating disorders, namely anorexia nervosa, bulimia nervosa, and compulsive overeating. In individuals with clinically diagnosed eating disorders seeking help, certain typological characteristics are observed, including difficulties in regulating self-esteem and emotions, issues with boundaries and a sense of healthy autonomy, impulse control problems, disruptions in basic trust in the world, and body image perception issues. Prominent individual personality traits include perfectionism, sensitivity to rewards and punishments, heightened anxiety, and a propensity towards obsessive states. These typological features in eating disorder patients lead to difficulties in psychotherapeutic relationships. Patients with food addiction often have concomitant anxiety and depressive disorders, including maladaptation.

Family factors are most often the trigger for the occurrence of eating disorders, namely conflicts in the family, mental and physical violence, high demands (control), and high levels of expectations. It is within the family that a child's body image is formed, so the attitude towards body shape and weight within the family can shape the child's attitudes and beliefs in an inadequate manner.

A review of the problem of providing psychological care to patients with various typological features emphasises that the use of only one specific model of psychotherapy care becomes ineffective due to the non-linear nature of the manifestation of the disorder. Studies show that personality can change due to important life events, such as psychotherapy, and that personality and relationships can predict treatment progress. It was possible to confirm the importance of typological features of eating disorder patients in the provision of psychotherapeutic care. The considered approaches to providing psychotherapeutic care and the

main personal characteristics of patients allow generalising the main traits associated with specific types of eating disorders to improve the effectiveness of choosing a strategy for psychotherapeutic care and establish psychotherapeutic relationships.

The scientific originality of the study lies in reviewing the main typological features of patients with anorexia nervosa, bulimia, and compulsive overeating. Differentiation and generalisation of the main personal characteristics of a dependent person help to create models of psychotherapeutic care, based on the individual characteristics of a certain group of patients.

The examination of key factors contributing to a personality inclined towards dependent behaviour, along with the family's influence on the development of eating disorders, offers opportunities for future research concerning the creation of a comprehensive psychological rehabilitation programme for patients with eating disorders.

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CONFLICT OF INTEREST

There are no conflicts of interest in the analysis of the issues raised.

REFERENCES

[1] Agras, W.S., & Bohon, C. (2021). Cognitive behavioral therapy for the eating disorders. *Annual Review of Clinical Psychology*, 17, 417-438. doi: 10.1146/annurev-clinpsy-081219-110907.

[2] Bemporad, J.R., Beresin, E., Ratey, J.J., O'Driscoll, G., Lindem, K., & Herzog, D.B. (1992). A psychoanalytic study of eating disorders: I. A developmental profile of 67 index cases. *Journal of the American Academy of Psychoanalysis*, 20(4), 509-531. doi: 10.1521/jaap.1.1992.20.4.509.

[3] Biliavska, O.D, & Medynska, Yu.Ya. (2022). *OPD2: Operationalized psychodynamic diagnosis based on an on-line platform*. Kyiv: Psyhobook.

[4] Bruch, H. (1980). Preconditions for the development of anorexia nervosa. *American Journal of Psychoanalysis*, 40(2), 169-172. doi: 10.1007/BF01254810.

[5] Bulik, C.M., Blake, L., & Austin, J. (2019). Genetics of eating disorders: What the clinician needs to know. *Psychiatric Clinics of North America*, 42(1), 59-73. doi: 10.1016/j.psc.2018.10.007.

[6] Careaga, M.B.L., Girardi, C.E.N., & Suchecki, D. (2016). Understanding posttraumatic stress disorder through fear conditioning, extinction and reconsolidation. *Neuroscience and Biobehavioral Reviews*, 71, 48-57. doi: 10.1016/j.neubiorev.2016.08.023.

[7] Cassin, S.E., Buchman, D.Z., Leung, S.E., Kantarovich, K., Hawa, A., Carter, A., & Sockalingam, S. (2019). Ethical, stigma, and policy implications of food addiction: A scoping review. *Nutrients*, 11(4), article number 701. doi: 10.3390/nu11040710.

[8] Claudat, K., Brown, T.A., Anderson, L., Bongiorno, G., Berner, L.A., Reilly, E., Luo, T., Orloff, N., & Kaye, W.H. (2020). Correlates of co-occurring eating disorders and substance use disorders: A case for dialectical behavior therapy. *Eating Disorders*, 28(2), 142-156. doi: 10.1080/10640266.2020.1740913.

[9] Collantoni, E., Meneguzzo, P., Solmi, M., Tenconi, E., Manara, R., & Favaro, A. (2019). Functional connectivity patterns and the role of 5-HTTLPR polymorphism on network architecture in female patients with anorexia nervosa. *Frontiers in Neuroscience*, 13, article number 1056. doi: 10.3389/fnins.2019.01056.

[10] Collantoni, E., Meneguzzo, P., Tenconi, E., Manara, R., & Favaro, A. (2019b). Small-world properties of brain morphological characteristics in Anorexia Nervosa. *PLoS One*, 14(5), article number e0216154. doi: 10.1371/journal.pone.0216154.

[11] Gorrell, S., Loeb, K.L., & Le Grange, D. (2019). Family-based treatment of eating disorders: A narrative review. *Psychiatric Clinics of North America*, 42(2), 193-204. doi: 10.1016/j.psc.2019.01.004.

[12] Costandache, G.I., Munteanu, O., Salaru, A., Oroian, B., & Cozmin, M. (2023). An overview of the treatment of eating disorders in adults and adolescents: Pharmacology and psychotherapy. *Postepy Psychiatrii Neurologii*, 32(1), 40-48. doi: 10.5114/ppn.2023.127237.

[13] Culbert, K.M., Racine, S.E., & Klump, K.L. (2015). Research Review: What we have learned about the causes of eating disorders – a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 56(11), 1141-1164. doi: 10.1111/jcpp.12441.

[14] Doerr-Zegers, O., & Pelegrina-Cetran, H. (2020). Phenomenology of corporeality (and spatiality) in anorexia nervosa with a reference to the problem of its temporality. In C. Tewes, & G. Stanghellini (Eds.), *Time and Body: Phenomenological and Psychopathological Approaches* (pp. 263-281). Cambridge: Cambridge University Press. doi: 10.1017/9781108776660.

[15] Esposito, C.M, & Stanghellini, G. (2020). The pathogenic and therapeutic potential of the gaze of the other in the clinic of "eating disorders." *Psychopathology*, 53(5-6), 291-297. doi: 10.1159/000509625.

[16] Fetahi, E., Stjerne Søgaard, A., & Sjögren, M. (2022). Estimating the effect of motivational interventions in patients with eating disorders: A systematic review and meta-analysis. *Journal of Personalized Medicine*, 12(4), article number 577. doi: 10.3390/jpm12040577.
[17] Fox, J.R.E., & Whittlesea, A. (2017). Accommodation of symptoms in anorexia nervosa: A qualitative study. *Clinical Psychology & Psychotherapy*, 24(2), 488-500. doi: 10.1002/cpp.2020.
[18] Fuchs, T. (2022). The disappearing body: Anorexia as a conflict of embodiment. *Eating and Weight Disorders – Studies on Anorexia, Bulimia and Obesity*, 27, 109-117. doi: 10.1007/s40519-021-01122-7.
[19] Galmiche, M., Déchelotte, P, Lambert, G., & Tavolacci, M.P. (2019). Prevalence of eating disorders over the 2000-2018 period: A systematic literature review. *American Journal of Clinical Nutrition*, 109(5), 1402-1413. doi: 10.1093/ajcn/nqy342.
[20] Garfinkel, P.E, & Gamer, D.M. (1982). *Anorexia nervosa: A multidimensional perspective*. New York: Brunner/Mazel.
[21] Gruber, M., König, D., Holzhäuser, J., Castillo, D.M., Blüml, V., Jahn, R., Leser, C., Werneck-Rohrer, S., & Werneck, H. (2020). Parental feeding practices and the relationship with parents in female adolescents and young adults with eating disorders: A case control study. *PloS One*, 15(11), article number e0242518. doi: 10.1371/journal.pone.0242518.
[22] Guarda, A.S., Schreyer, C.C., Boersma, G.J., Tamashiro, K.L., & Moran, T.H. (2015). Anorexia nervosa as a motivated behavior: Relevance of anxiety, stress, fear and learning. *Physiology & Behavior*, 152 (Pt B), 466-472. doi: 10.1016/j.physbeh.2015.04.007.
[23] Harrison, A, Stavri, P, & Tchanturia, K. (2020). Individual and group format adjunct therapy on social emotional skills for adolescent inpatients with severe and complex eating disorders (CREST-A). *Neuropsychiatrie*, 35(4), 163-176. doi: 10.1007/s40211-020-00375-5.
[24] Hay, P. (2020). Current approach to eating disorders: A clinical update. *Internal Medicine Journal*, 50(1), 24-29. doi: 10.1111/imj.14691.
[25] Keel, P.K., Brown, T.A., Carter, L.H., & Bodell, L.P. (2012). Empirical classification of eating disorders. *Annual Review of Clinical Psychology*, 8(1), 381-404. doi: 10.1146/annurev-clinpsy-032511-143111.
[26] Kernberg, O.F. (2018). Commentary on the psychodynamic diagnostic manual, 2nd edition: What does the PDM-2 add to the current diagnostic panorama? *Psychoanalytic Psychology*, 35(3), 294-295. doi: 10.1037/pap0000208.
[27] Kovács-Tóth, B., Oláh, B., Kuritárné Szabó, I., & Túry, F. (2022). Adverse childhood experiences increase the risk for eating disorders among adolescents. *Frontiers in Psychology*, 13, article number 1063693. doi: 10.3389/fpsyg.2022.1063693.
[28] Kroplewski, Z., Szcześniak, M., Furmańska, J., & Gójska, A. (2019). Assessment of family functioning and eating disorders – the mediating role of self-esteem. *Frontiers in Psychology*, 10, article number 921. doi: 10.3389/fpsyg.2019.00921.
[29] Levinson, C.A, Hunt R.A, Keshishian, A.C, Brown, M.L., Vanzhula, I., Christian, C., Brosof, L.C., & Williams, B.M. (2021). Using individual networks to identify treatment targets for eating disorder treatment: A proof-of-concept study and initial data. *Journal of Eating Disorders*, 9(1), article number 147. doi: 10.1186/s40337-021-00504-7.
[30] Loxton, N.J, & Dawe, S. (2009). Personality and eating disorders. In P.J. Corr, & G. Matthews (Eds.), *The Cambridge handbook of personality psychology* (pp. 687-703). Cambridge: Cambridge University Press.
[31] Malet-Karas, A., Bernard, D., Piet, E., & Bertin, E. (2022). Disordered eating as a repercussion of sexual assault: A consequence to consider. *Eating and Weight Disorders*, 27(6), 2095-2106. doi: 10.1007/s40519-021-01356-5.
[32] Miller, W.R., & Rose, G.S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, 64, 527-537. doi: 10.1037/a0016830.
[33] Minuchin, S, Nichols M.P, & Lee, W.-Y. (2007). *Assessing families and couples: From symptom to system*. Boston: Allyn & Bacon.
[34] Miranda-Olivos, R., Agüera, Z., Granero, R., Jiménez-Murcia, S., Puig-Llobet, M., Lluch-Canut, M.T., Gearhardt, A.N., & Fernández-Aranda, F. (2023). The role of food addiction and lifetime substance use on eating disorder treatment outcomes. *Nutrients*, 15(13), article number 2919. doi: 10.3390/nu15132919.
[35] National Eating Disorders Association. (n.d.). *Statistics & research on eating disorders*. Retrieved from https://www.nationaleatingdisorders.org/statistics-research-eating-disorders.
[36] Obbarius, A., Obbarius, N., Fischer, F., Liegl, G., & Rose, M. (2018). Evaluation of factor structure and construct validity of the 12-item short version of the OPD structure questionnaire (OPD-SQS) in psychosomatic patients. *Psychotherapie, Psychosomatik, Medizinische Psychologie*, 69(1), 38-48. doi: 10.1055/s-0043-125394.
[37] Palmisano, G.L., Innamorati, M., Susca, G., Traetta, D., Sarracino, D., & Vanderlinden, J. (2018). Childhood traumatic experiences and dissociative phenomena in eating disorders: Level and association with the severity of binge eating symptoms. *Journal of Trauma & Dissociation*, 19(1), 88-107. doi: 10.1080/15299732.2017.1304490.
[38] Paris, B.J. (1997). Karen Horney's vision of self. *American Journal of Psychoanalysis*, 59, 157-166.

[39] Piccinni, A., Bucchi, R., Fini, C., Vanelli, F., Mauri, M., & Stallone, T. (2020). Food addiction and psychiatric comorbidities: A review of current evidence. *Eating and Weight Disorders*, 26(4), 1049-1056. doi: 10.1007/s40519-020-01021-3.
[40] Polivy, J., & Herman, C.P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213. doi: 10.1146/annurev.psych.53.100901.135103.
[41] Prochaska, J.O., & DiClemente, C.C. (2005). The transtheoretical approach. In J.C. Norcross, & M.R. Goldfried (Eds.), *Handbook of psychotherapy integration* (3rd ed.; pp. 161-210). Oxford: Oxford University Press. doi: 10.1093/med-psych/9780190690465.003.0008.
[42] Ralph-Nearman, C., Achee, M., Lapidus, R., Stewart, J.L., & Filik, R. (2019). A systematic and methodological review of attentional biases in eating disorders: Food, body, and perfectionism. *Brain and Behavior*, 9(12), article number e01458. doi: 10.1002/brb3.1458.
[43] Reich, G., & Cierpka, M. (1998). Identity conflicts in bulimia nervosa: Psychodynamic patterns and psychoanalytic treatment. *Psychoanalytic Inquiry*, 18(3), 383-402. doi: 10.1080/07351699809534199.
[44] Rohde, J., Hofmann, T., Voigt, B., Rose, M., & Obbarius, A. (2019). Measurement of personality structure by the OPD structure questionnaire can help to discriminate between subtypes of eating-disorders. *Frontiers in Psychology*, 10, article number 2326. doi: 10.3389/fpsyg.2019.02326.
[45] Rosania, K., & Lock, J. (2020). Family-based treatment for a preadolescent with avoidant/restrictive food intake disorder with sensory sensitivity: A case report. *Frontiers in Psychiatry*, 11, article number 350. doi: 10.3389/fpsyt.2020.00350.
[46] Smink, F.R.E., van Hoeken, D., & Hoek, H.W. (2013). Epidemiology, course, and outcome of eating disorders. *Current Opinion in Psychiatry*, 26(6), 543-548. doi: 10.1097/YCO.0b013e328365a24f.
[47] Treasure, J., Willmott, D., Ambwani, S., Cardi, V., Bryan, D.C., Rowlands, K., & Schmidt, U. (2020). Cognitive interpersonal model for anorexia nervosa revisited: The perpetuating factors that contribute to the development of the severe and enduring illness. *Journal of Clinical Medicine*, 9(3), article number 630. doi: 10.3390/jcm9030630.
[48] Waller, G., & Raykos, B. (2019). Behavioral interventions in the treatment of eating disorders. *Psychiatric Clinics of North America*, 42(2), 181-191. doi: 10.1016/j.psc.2019.01.002.
[49] Westen, D., & Harden-Fischer, J. (2001). Personality profiles in eating disorders: Rethinking the distinction between Axis I and Axis II. *American Journal of Psychiatry*, 158(4), 547-562. doi: 10.1176/appi.ajp.158.4.547.
[50] Westen, D., Novotny, C.M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, 130(4), 631-663. doi: 10.1037/0033-2909.130.4.631.
[51] Wooldridge, T. (2022). Binge eating disorder: The subjugation of the "hungry self". *Psychoanalytic Psychology*, 39(4), 287-294. doi: 10.1037/pap0000408.
[52] World Health Organisation. (2010). Sixty-Third World Health Assembly: Resolutions and decisions annexes. Geneva: WHO.

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Типологічні особливості пацієнтів з розладами харчової поведінки: огляд публікацій

Анотація. Незважаючи на те, що розвиток та перебіг різних видів розладів харчової поведінки, а отже, і лікування цих порушень значною мірою залежить від типологічних особливостей пацієнтів, цьому аспекту присвячено недостатню кількість наукових досліджень. Огляд проблеми надання психологічної допомоги пацієнтам з різними типологічними особливостями, що мають розлади харчової поведінки, і став метою дослідження. За допомогою методів аналізу, синтезу та порівняння в статті представлено значення типологічних особливостей пацієнтів з розладами харчової поведінки в наданні психотерапевтичної допомоги. З'ясовано, що пацієнти з певними рисами особистості, як-от: перфекціонізм, необхідність контролю та імпульсивність – схильні до розладів харчової поведінки, водночас показано, що ці типологічні особливості особистості поряд з багатьма іншими допомагають будувати стратегії лікування від нервової анорексії, компульсивного переїдання та нервової булімії. Аналіз показав, що існують риси, специфічні для певних розладів харчової поведінки, які можуть бути посилені в процесі подолання харчової залежності. Виявлено вплив особистісних особливостей на вибір стратегії психотерапевтичної допомоги, а також можливості формування психотерапевтичних відносин. Розкрито значення типологічних особливостей пацієнтів з розладами харчової поведінки в наданні психотерапевтичної допомоги. Узагальнено основні особистісні характеристики за типом харчового розладу з метою поліпшення ефективності вибору стратегії психотерапевтичної допомоги, а також можливості формування психотерапевтичних відносин. Надається увага типовим поведінковим проявам за наявності одного з видів харчового розладу. Обґрунтовано основні передумови формування особистості, схильної до залежної поведінки. Сформовано основне бачення ролі сім'ї у формуванні розладу харчової поведінки. Практична цінність статті полягає в можливості використати матеріали дослідження для розширення уявлень про типологічні особливості пацієнтів з харчовою залежністю задля надання ефективної психотерапевтичної допомоги

Ключові слова: харчова залежність; нервова анорексія; нервова булімія; компульсивне переїдання; психотерапевтична допомога