

Therapeutic difficulties in management of the patient with anorexia nervosa and comorbid borderline personality disorder – case study

Katarzyna Korczyńska, Barbara Kostecka, Paweł Sala,
Katarzyna Kucharska

Summary

Aim: This case report addresses some clinical challenges occurring throughout the therapeutic process of specialized management and treatment of anorexia nervosa with comorbid borderline personality disorder.

Materials and method: Clinical examinations and measures – Structured Clinical Interview for DSM-IV (SCID-II), Eating Attitudes Test (EAT-26), Yale-Brown Obsessive Compulsive Scale modified for Body Dysmorphic Disorder (BDD-YBOCS), Beck Depression Inventory-II (BDI-II), Toronto Alexithymia Scale (TAS-20), and State-Trait Anxiety Inventory (STAI) have been employed to identify the nature and severity of patient's psychopathology and its potential change throughout the therapeutic process.

Results: Despite some improvement in the symptoms of the eating disorder following treatment, some other measures of psychopathology (e.g., depression) remained at similar level. **Discussion:** Management of AN with comorbid BPD requires a comprehensive care package including integrative psychotherapy, nutritional interventions and pharmacotherapy at an inpatient setting as well as follow-up care thereafter.

Conclusions: Only partial improvement in the profile of F.C.'s psychopathology was observed.

anorexia nervosa, borderline personality disorder, clinical management, resistance

BACKGROUND

There is a body of evidence that suggests association between Eating Disorders (ED) and Borderline Personality Disorders (BPD) [1-3]. Meta-analysis suggests that between 21% and 90% of Anorexia Nervosa (AN) and Bulimia Nervosa (BN)

patients have a comorbid Personality Disorder (PD), whereas the prevalence rates of PD in Eating Disorders Not Otherwise Specified (EDNOS) sample range from 26% to 51% [4]. Great variability in the reported prevalence rates is thought to be related to methodological issues. Some data relies on patients' self – reports and some on clinical interviews [1]. It is suggested that self-reports tend to overestimate the prevalence rates for the comorbidity [1]. Another methodological issue is that studies accounting for the comorbidity remain underreported [5].

Diagnosis of BPD per se does not provide any insights into co-occurring ED. However, there

Katarzyna Korczyńska¹, Barbara Kostecka², Paweł Sala³, Katarzyna Kucharska⁴: ¹ University of Groningen, the Netherlands; ^{2,4} Department of Neuroses, Personality Disorders and Eating Disorders, Institute of Psychiatry and Neurology, Warsaw, Poland; ³ Private Psychotherapeutic Practice, Warsaw, Poland
Correspondence address: kate.pietura@googlemail.com

are certain characteristics that are common in both disorders, for example, BPD and BN may share difficulties in affect regulation and impulsivity, whereas BPD and AN tend to share self-destructive behaviors [6]. Even though there are some similarities between ED and BPD, how these disorders relate in terms of development or etiology appears to not be fully understood.

It has been proven that ED patients with the secondary diagnosis of BPD tend to have poorer therapeutic outcomes [1]. Thus, understanding the pattern and prevalence of this comorbidity is relevant for the assessment and treatment of eating disorders. For individuals with ED and comorbid BPD, Cognitive Behavioral Therapy (CBT) or interpersonal psychotherapy may have limited effectiveness [7]. Therefore, additional approaches may be needed to overcome therapeutic difficulties (e.g., with the focus on emotion regulation and distress tolerance as suggested in Dialectical Behavioral Therapy, enhanced Cognitive Behavioral Therapy [CBT-E], or Schema-Focused Therapy) [8]. According to the National Institute of Mental Health (NIMH) and the National Institute for Health and Care Excellence (NICE) guidelines [8], psychotherapy is the first-line treatment for patients with BPD. A therapist can provide one-on-one treatment or treatment in a group setting. Therapist-led group sessions may help to teach patients with BPD how to interact with others and how to effectively express their thoughts and feelings. It is important that patients in therapy get along with, and trust their therapist. The very nature of BPD can make it difficult for patients with the disorder to maintain a comfortable and trusting bond with their therapist. Two examples of psychotherapies used to treat BPD include:

- **Dialectical Behavior Therapy (DBT)** – was developed for patients suffering from borderline personality disorder. DBT uses concepts of mindfulness and acceptance or being aware of and attentive to the current situation and emotional state. Moreover, DBT teaches skills helpful in controlling intense emotions, reducing self-destructive behaviors and improving relationships.
- **Cognitive Behavioral Therapy (CBT) or enhanced CBT** – can help patients with BPD identify and change core beliefs

and behaviors that underlie inaccurate perceptions of themselves and others, and that result in problems with interpersonal interactions. Additionally, CBT may be helpful in reducing a range of mood and anxiety symptoms as well as suicidal or self-harming behaviors. [9]

The aim of this article is to review the care and management of the patient suffering from AN and comorbid BPD against well respected guidelines (i.e., NICE and NIMH), with usage of clinical outcome measures [8]. F.C.'s eating disorders commenced at the age of 14. She began to lose weight in order to be more liked and to feel better about herself and her body. Consequently, she developed an irregular eating pattern, alternating between phases of starvation and compulsive eating. She has been under the care of a psychiatrist from the age of 17. At that time, she was diagnosed with anorexia nervosa and received treatment on an outpatient basis, however, she was noncompliant with the treatment plan since she did not take any prescription medicine. At the age of 20, she was reassessed at the Psychological Counselling Center and received a diagnosis of bulimia nervosa with comorbid mild depressive episode. Moreover, she was said to display some characteristics of obsessive-compulsive personality disorder. She was undergoing pharmacological treatment – fluoxetine (up to 60 mg daily) and topiramate (50 mg daily). At that time, she was studying at the University of Technology. She was very ambitious, perfectionistic, and study oriented. However, at the university, she felt pressured by the high study demands. She became overloaded and due to her symptoms, she needed to repeat the first year. She experienced a loss of energy and motivation, and presented with a decreased mood. She started to cut, burn and punch herself as a method of self-harm. Eventually, the patient dropped out of the University of Technology and started a bachelor's degree at the University of Arts.

From the age of 23, she was self-medicating herself with pseudoephedrine to decrease her appetite and control her weight. She was also occasionally substituting her food intake with alcohol. At the age of 24, she was referred to the ED inpatient clinic and she pursued her recovery.

SOCIAL AND FAMILY HISTORY

F.C. reported to have a weak relationship with all of her family members and to have no close friends. She postulated that she did not share her inner experiences and emotional states with other people. She said that emotion sharing, or other acts of emotional intimacy, were rather uncommon or even discouraged in her family and perceived as odd or weird. There were no reports of domestic violence or pathology. F.C.'s social contacts at school and at university had been limited to study mates. She had never been in any romantic relationship, nor had she ever fallen in love. F.C. performed very well academically at school. Her favorite subject was mathematics. She reported to have more social interactions with study mates when her weight was low, which was related to her higher self-esteem and improved self-confidence at those times. F.C. started her studies at the University of Technology but was not able to continue the program because of a depressive episode. After the episode, she started her studies at the University of Arts. She also worked as a cashier in a store. Eventually, she took a break from studies and work to pursue her recovery in an ED inpatient clinic.

With regards to her family history, F.C. assumed that both her grandmother and mother could have suffered from depression. She is not aware of a clinical diagnosis for her grandmother but confirmed that her mother had suffered from postpartum depression after the patient's birth. The patient has not described her mother as a safe object throughout the developmental stages. She was either absent or "not there" during the patient's childhood. In her role as a mother, she was socially withdrawn with fairly long periods of nostalgia and apathy. She presented with difficulties in expressing positive comments and warmth towards family members, however, expected the patient "to be a good girl". She was very expressive in her comments, such as those regarding F.C.'s behavior and school achievement. The mother was often absent while being preoccupied either with work or feeling unwell due to "depression". During the mother's unavailability, the patient's care was assumed by F.C.'s grandmother, who was described by the patient as "always busy

with stuff" and rather cold. F.C. did not develop any emotional bond with her.

As for her father, the patient did not want to talk about him since he remains unknown to her. He had a 'technical' brain since he worked as an engineer and had a very practical approach towards life. The patient has described him as unemotional. F.C. does not remember any holidays with him and she claims that he has not been involved in family life. The patient proudly described her father as a high achiever in his professional life. The family dynamics mentioned above remain in accordance with the modern attachment theory based on studies investigating children and their caregivers. The theory highlights the importance of early parent-child interactions for children's future ability to build secure attachments. Hazan and Shaver applied the attachment theory to adult relationships [10].

According to the modern attachment theory, securely attached people consider it relatively easy to become emotionally close to others. They tend to have positive views of themselves, their attachments, and relationships. Secure attachment and adaptive functioning are promoted by a caregiver who is emotionally available and appropriately responsive to his/ her child's attachment behavior, as well as capable of regulating his/her own positive and negative emotions [11].

F.C. sadly developed an insecure, dismissive-avoidant attachment style. She stated that she feels comfortable without close emotional relationships. She presented major difficulties in asking for help as it was important to her to feel independent and self-sufficient. People with this attachment style desire a high level of independence. The desire for independence is often an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. F.C. often denied needing close relationships or even viewed close relationships as relatively unimportant. Clinicians commonly noted the defensive character of this attachment style. People with a dismissive-avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection or abandonment by distancing themselves from the sources of rejection (e.g., their attachments or relationships).

MENTAL STATE EXAMINATION ON ADMISSION

Despite limited eye contact, an adequate rapport was established. F.C.'s speech was fluent and coherent. While being questioned, she answered in an adequate manner, disclosing a sufficient amount of information. Conversation could be easily followed. She did not seem to display any psychotic tendencies or disruptions in her speech or thought pattern. Her memory, language comprehension and intellectual functioning seemed intact. There were no grounds to suspect deception. During the examination, the patient was distant and serious. She appeared to be preoccupied with self-control, which expressed itself in controlled movements and rigid body posture. F.C. had some insight into her health condition. Her initial attitude towards therapy was skeptical with little hope for recovery. She stated that she decided to undergo therapy, as she had tried everything else and nothing had helped thus far. She reported a decreased mood. She had performed self-harm behaviors in the past in the form of cutting, burning and punching. She did not report having any suicidal thoughts or intentions to harm others. She claimed to have a chronic feeling of emptiness and problems with self-identity – "Who am I with no illness?".

ADMISSION

F.C. has been seeking help for her eating disorders for the last five years. The treatment that she has received on the outpatient basis did not yield satisfactory results. Therefore, she has been offered a comprehensive treatment package in the inpatient clinic. Upon admission, F.C. reported withdrawal from social life. In order to help the patient re-engage in the social context and reactivate her in her social roles she has been offered integrative therapy that was adjusted to the needs of the patients with eating disorders. This therapy included social skills training and neurocognitive training that together was aimed at improving social cognition, interpersonal functioning, and focused on perspective taking and emotional regulation. Careful inspection of F.C.'s past psychiatric history revealed that F.C. was primarily di-

agnosed with anorexia nervosa. At the time, she lost a significant amount of weight and, consequently, experienced an increase in self-esteem. In the course of time, she started losing control over her eating behavior. Phases of starvation became intertwined with phases of compulsive eating. As the frequency of her bingeing episodes increased, she gained weight, her display of affect was reduced, and her diagnosis was changed to bulimia nervosa with mild depressive episode. She then began psychopharmacotherapy. At admission, F.C.'s weight was 58.3kg and her BMI was 21.9. Most of her presenting complaints were related to eating disorders. She reported having binge eating episodes and compensations in the form of purging. She described her eating pattern as unstable with interchanging episodes of bingeing and restrictive dieting. She presented with distorted body image and described her body as fat and disgusting.

Aside from the symptomatology related to eating disorders, F.C. displayed a set of characteristics associated with borderline personality disorder. In addition to confusion about her identity ("Who am I with no illness?"), instability in personal goals and self-direction became evident. She claimed to have "no real hobbies" or aspirations. She stated that she quickly becomes bored and disengages from activities she partakes in. She tried drawing, dancing and playing the guitar, all of which she dropped. Furthermore, F.C. kept changing her vocational and educational plans. A lack of self-directedness contributed to her confusion about her self-concept, feelings of inner-emptiness and it bothered her that she could not define who she "really is". Another feature of BPD was evident in the way she had been forming relationships. She neither had close friends nor romantic relations. She met with her peers exclusively in a school environment for educational rather than social purposes. She reported being skeptical towards people and lacked emotional connection to them. These superficial social bonds, however, could not be explained in terms of other personality disorders. In contrast to narcissistic personality disorder, she neither experienced a sense of grandiosity nor did she want to be in the center of attention. Furthermore, she was sensitive to negative feedback. It became apparent that

the absence of social bonds and the strong sense of independence was caused rather by a fear of abandonment than a lack of actual needs to connect (e.g., as evident in avoidant personality disorder). Despite distancing herself from others, she has had a need to be liked. She often described putting on a “mask” to fit in and meet social expectations. Next, she presented with impulsive behaviors (e.g., cutting, punching, burning, overdosing on alcohol). In addition to primary investigations, further psychological tests were administered that revealed high levels of alexithymia and very low scores on emotional empathy and altruism.

A joint consultation including staff members engaged in the therapeutic process of F.C. took place to verify her clinical diagnosis. The diagnosis was made based on completing a thorough psychiatric interview, which included a discussion about symptoms and family history of mental illness, and performing a careful medical exam, which can help rule out other possible causes of symptoms. At the time of admission, she fulfilled the DSM-V criteria for bulimia nervosa (mixed type) and borderline personality disorder (301.83). A comprehensive diagnostic process with usage of clinical diagnostic measures resulted in a change of diagnosis from bulimia nervosa to anorexia nervosa – purging subtype with comorbid borderline personality disorder (DSM-V). As the previous treatment of the patient on the outpatient basis did not yield improvement in the ED symptomatology, F.C. was admitted to the inpatient treatment unit. She was assigned to group A in the Department of Neuroses, Personality Disorders, and Eating Disorders, which was dedicated to the treatment of patients suffering from ED, which was in line with F.C.’s primary diagnosis. Since the patient’s complaints focused mostly on the symptoms related to ED and her clinical record indicated that her eating disorders contributed the most to experienced clinical burden, the diagnostic team decided to start her treatment by addressing predominantly AN psychopathology with some aspects of BPD. The patient was offered a wide range of therapeutic activities including: group therapy, individual therapy, behavioral therapy, psychoeducation, art therapy, music therapy, psychodrama, and social and neurocognitive training.

CLINICAL ASSESSMENT

F.C. was evaluated twice on all measures, excluding the Structured Clinical Interview for DSM-IV (SCID-II). The first round of measurements took place upon admission and the second round at 2 weeks prior to discharge. SCID-II was administered only once – upon admission. F.C.’s eating psychopathology was evaluated using the Eating Attitudes Test (EAT-26), a self-reported measure. Results revealed a very significant decrease in the symptoms of the eating disorder from the first assessment to the second. F.C. was screened for comorbid Personality Disorders using the Structured Clinical Interview for DSM-IV, SCID-II. Results of the interview indicated co-occurrence of BPD (6/9 diagnostic criterion; cut off – 5) as well as Avoidant Personality Disorder (AvPD) (4/7 diagnostic criterion; cut off – 4). Following SCID-II, Yale-Brown Obsessive-Compulsive Scale modified for Body Dysmorphic Disorder (BDD-YBOCS) was administered to assess obsessive-compulsive symptoms and avoidance tendencies related to distorted body image. In correspondence to clinical guidelines, both BDD-YBOCS scores were classified as high (cut off – 20) and a drop from the first measurement to the second was nonsignificant. Next, F.C. was evaluated on Beck Depression Inventory II (BDI-II), a self-reported measure of depressive symptoms. In relation to guidelines, both measurements indicated severe depressive symptoms (cut off score – 29) with a small increase in symptoms at the second measurement. Subsequently, State-Trait Anxiety Inventory (STAI) was administered. STAI consists of two subscales: the first measuring situational anxiety and the second measuring dispositional anxiety. There was a decrease on both anxiety subscales from the first measurement to the second and the effect was greater for the dispositional subscale. Furthermore, F.C. appeared highly alexithymic at both measurements, with a small decrease on the second assessment. Alexithymia levels were measured using Toronto Alexithymia Scale (TAS-20), which measures deficits in cognitive processing and regulation of emotions that contribute to the difficulties in describing and identifying emotional states.

The reduction of symptoms of clinical relevance was only obtained on EAT-26 and STAI

scales. The rest of the scales remained at a similar level in relation to baseline assessment.

Table 1. Psychological analyses and their results performed in acute phase and remission, respectively.

Test	Results: Assessment I	Results: Assessment II
TAS-20	76	69
BDI-II	35	40
EAT-26	56	25
STAI	X-I: 48 X-II: 60	X-I: 42 X-II: 46
BDD-YBOCS	28	26

FURTHER MANAGEMENT AND DISCHARGE

During hospitalization, F.C. was provided with a comprehensive care package that included integrative psychotherapy, nutritional intervention, and pharmacotherapy. With regards to the offer of psychotherapy, she attended group therapy (3 times weekly), individual psychotherapy sessions (once weekly), dance therapy (once weekly), art therapy (twice weekly), body image program (once weekly), social cognitive and neurocognitive training (once weekly), psychodrama (once weekly), music therapy (once weekly), and psychoeducation (once weekly). Her group therapy was CBT based, however, her individual therapist conveyed psychotherapeutic sessions in psychodynamic mode.

According to NICE guidelines for adults with anorexia nervosa, individual eating disorder-focused cognitive behavioural therapy (CBT-ED) is recommended [8]. Individual CBT-ED programs should typically consist of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks.

As the treatment progressed, the patient became more active during group therapy and other therapeutic activities, though she remained very sensitive to environmental circumstances. F.C. started to engage in group discussions more frequently, relative to the beginning of the treatment. Even though there was an observable increase in the patient's activity level, F.C. remained distant towards the therapist and fellow patients. She was reluctant to talk about herself and her personal experiences. At times, she

would cross boundaries related to therapeutic regulations or group functioning, for instance, she did not obey regulations concerning minimal food consumption and started sabotaging rules on the ward and displaying maladaptive behaviors during group sessions.

During the treatment, F.C. signaled concerns regarding her social functioning. She also complained about depressive and anxiety symptoms. She was markedly worried about her future after discharge. It was recommended for F.C. to continue treatment in an outpatient setting post discharge.

DISCUSSION

F.C. possessed a history of a large amount of emotional abandonment and neglect. It provoked limited awareness of internal experiences (i.e. feelings, wants, needs, values) that would allow F.C. to build a sense of self. This also resulted in identity confusion and fragmentation, pervasive feeling of emptiness, inadequacy, and a sense of worthlessness and powerlessness. For many years she has learned to rely on avoidance to cope with strong feelings generated as a response to her abandonment. Her emotional dysregulation included recurrent incidents of self-harm. For F.C., habitual forms of emotional avoidance were dieting, binge eating and purging. Chronic inhibition of feelings associated with trauma resulted in tension that contributed to depressive and anxiety syndromes.

During complex psychotherapy, F.C. experienced an improvement in symptoms related to eating pathology. It was evident in significant improvement in all subscales of EAT-26 (dieting, bulimia and oral control). F.C. decreased her self-harming behaviors and started to work towards more adaptive coping strategies with regards to her feelings. In the past, she was externally focused and attuned to signs of danger, overly vigilant, and highly responsive to the needs of others, especially her depressive mother. During psychotherapy, she started to recognize and communicate her feelings. An example of this important change in her attitude could be observed in situations when she revealed her strong emotions during early drop-out of fellow patients or therapist's absence.. These were very

early signs of change and they became more evident as scores slowly decreased on STAI subscales that together were measuring state and trait anxiety. Sala, in his research [13,14], found that severity of anxiety and depressive symptoms among patients with anorexia and bulimia diminished during complex psychotherapy. However, among the patients that were studied by Sala, there were patients with eating disorders with no comorbid diagnoses. This may explain the slower pace of psychotherapeutic change in this case study as it concerned symptoms in a patient with concomitant personality disorder. Sustaining severity of depressive symptoms could be explained by persistent, long-lasting emotional pain which might have artificially inflated scores on the inventory designed for depression. It would also mean that the process of negative affect regulation which can be seen as a baseline in the psychotherapy concomitant borderline personality has already started and has had no impact upon depressive symptoms yet. Slight weight loss at the end of therapy (50,8 kg) is coherent with persistent obsessive thoughts of distorted self-image (BDD-YBOCS, EAT-26).

FINAL CONCLUSIONS

Management of anorexia nervosa with comorbid borderline personality disorder constitutes a great clinical challenge. Undoubtedly, it is a longitudinal process that requires the cooperation of specialists from many different disciplines (e.g., psychotherapists, dieticians, and health care practitioners). Detrimental emotion regulation, impulsivity, and difficulties in building healthy social relationships can hinder therapeutic progress but, at the same time, should be the primary purpose of long-term therapeutic strategies. The main short-term goal of F.C.'s treatment was to manage her eating disorder pathology. It lasted twelve weeks. Although a reduction of ED symptoms and self-harm behaviors was observed following the treatment, there was no change in depressive symptoms. In this case, next to addressing eating disorders symptoms, further clinical formulation and long-term management of borderline personality disorder symptoms is strongly needed.

Therapeutic guidelines and interventions that account for comorbidity could benefit the treatment of patients like F.C. It may be helpful to address symptoms that are common between two or more diagnoses. Identification and management of trans-diagnostic factors can help to reduce the impact of symptoms across different diagnoses and help to enhance the functioning of the individual in many different domains of life. With regards to the management of AN with comorbid BPD, promising results yield CBT-E and DBT aimed at addressing other adaptive emotional regulation strategies and mindfulness techniques to manage stress and rumination of intrusive thoughts.

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