

Article 32

Treating Eating Disorders With the Buddhist Tradition of Mindfulness

Marty Slyter

Slyter, Marlene (Marty) J., is the Counseling Program Director, Coordinator of the School Counseling Program and Assistant Professor at Eastern Washington University. She has been a school counselor for 25 years and is also a Licensed Mental Health Therapist. She has worked with many eating disordered individuals and has presented a variety of workshops and presentations on eating disorders.

Successfully treating the eating disorders of anorexia nervosa, bulimia nervosa and binge eating disorder continues to be a challenge for treatment providers. Western psychology has become increasingly interested in using the original Buddhist practice of mindfulness as a means to therapeutic change. Since the introduction of mindfulness in Western clinical settings, a large number of studies have documented its beneficial effect on psychological distress and well-being. Few studies have specifically looked at using mindfulness as a treatment component for eating disorders. This article looks at the role of mindfulness in treating eating disorders as part of a comprehensive treatment paradigm.

Andersen (2007) talks about a group of four high school students who were having lunch together on a Saturday afternoon. It was a fun place with warm colors and authentic food.

After the food arrived, John immediately thought back to how his wrestling coach had warned him about getting too fat in the off-season. With mechanical action he ate, but his mind was on that interaction when he determined he would never be criticized again for his weight. He wanted the coach to get off his case, but John could not get off his own case. Gun to the head, he couldn't say after the meal what he had eaten.

Sue got nervous as soon as she took one look at the tortilla chips and mango salsa the waiter had put on the table before they even ordered, and once her Santa Fe chicken salad arrived, Sue feared that she would never fit into her prom dress in a few weeks. While her jaws worked, she saw herself trying to squeeze into her beautiful gown, its seams tearing on the dance floor. The image felt so real, she could sense her anger and disgust rising against her hips. Food? What food? The plate was clean, but so was the memory of the food.

Joan ordered a plank steak with hot peppers, but you would never know it if you asked her afterwards. That food, that smell, that plate of food radiated anxiety and brought her back to when her boyfriend patted her on the hips and said she was getting a little heavy. Her stomach churned and she could barely swallow. She

relived the rage that boiled inside, but she stuffed the anger so she wouldn't lose the boyfriend. She thought of all the things she could have said, but never did.

Brad decided on the house special which sounded good when the waiter described it to him. While he was eating, he had no idea what the food tasted like. It was like a silent movie. He said some phrases to the others but couldn't remember these. It was a script. His mind was on those years in junior high school when he was teased mercilessly as a "fat slob." The humiliation was still there tingling in his bones, even three or four years later, and it was certainly more real than the flavors of the house special. His body was drenched in sweat, and even with these close friends, he was afraid they were judging him. (p. 279)

When the group got together on campus the following Monday, it was sad, funny, and puzzling. None of them could remember their morning showers or even what they had studied in their classes moments earlier. Their minds were everywhere else. One look at their stomachs during the lunch sent the two girls into old tapes of how much they disliked their bodies. One look at their chests and shoulders during the lunch sent the two boys into a panic about the past and future. They were there, but they weren't there (Andersen, 2007).

The students' story is often repeated with different characters and scenarios as people navigate through living, unaware and not mindful of what is currently happening. Western culture appears to influence feeling frantic, disjointed, unsettled, and having past and future orientations dominate. As noted in the students' story, these students were experiencing those feelings and orientations in connection with their relationships with food and body image.

For those that struggle with relationships with food and disordered eating, could learning how to not feel so frantic, disjointed, and unsettled help them? One method that seems to have promise is learning and practicing the techniques of *mindfulness*, a life style that is based on the Buddhist tradition of mindfulness (Kabat-Zinn, 2003).

This article will first define mindfulness and its role in psychological treatment and then briefly define three major eating disorders. The final section will look at the role of mindfulness in the treatment of eating disorders.

Mindfulness in Psychological Treatment

Mindfulness meditation is one of several meditations in Buddhist practice. Mindfulness includes goals such as enhancing well-being and awareness of the self and environment, along with disciplining the emotions and the mind (Levine, 2000). Within the therapeutic context, mindfulness is defined as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003, p. 145). Bishop et al. (2004) defined the Western version of mindfulness as nonelaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as is. Many psychological interventions that involve the integration of Eastern and Western philosophies started appearing in the 1970s. Since the introduction of mindfulness into clinical settings, a large number of studies have documented its beneficial effect on psychological distress and well-being (Grossman, Niemann, Schmidt, & Walach, 2004; Shigaki, Glass, & Schopp, 2006).

Kabat-Zinn (1982) created the Mindfulness-Based Stress Reduction (MBSR) program, and this program played a key role in growth and acceptance of mindfulness in clinical circles. MBSR is rooted in authentic Buddhist traditions, particularly those practiced in certain parts of

South East Asia (Kabat-Zinn, 1990). The particular Buddhist tradition from which MBSR is derived appears to be an adapted version of the original Indian practice of mindfulness. MBSR has further changed the adapted Buddhist practice into a multi-component intervention to suit the Western mindsets and needs (Rapgay & Bystrisky, 2009). MBSR was originally developed for the management of chronic pain and stress-related disorders. Modern Western versions of mindfulness incorporate the following:

- attention and acceptance are key defining features instead of attention and introspective awareness
- not goal oriented
- not phase and process oriented
- cognitive in nature rather than perceptual in nature
- focus on present moment experiences instead of present, past and future experiences
- attention and awareness are not differentiated states
- a non-reactive awareness
- sequential application of attention and awareness
- mindfulness is value based such as active acceptance and affective processing (Rapgay & Bystrisky, 2009)

Mindfulness-Based Cognitive Therapy (MBCT) is now a well-established mindfulness based health intervention with roots in the work of Kabat-Zinn's MBSR program. MBCT was developed in the 1990s by Segal, Williams, and Teasdale and is designed to help prevent relapse in depression (2002). Like MBSR, it is also considered to be beneficial for other conditions. MBCT is a strong example of Western psychology's interest in mindfulness as a means to therapeutic change (Gilpin, 2008). MBCT developed within the field of cognitive behavioral therapy (CBT). It is based upon the assumption that the way we perceive events largely determines how we feel about them, and, in turn, how we behave. CBT aims to replace the client's presumed distorted appraisal of life events with more realistic and adaptive ones, via monitoring automatic thoughts, testing their validity, substituting more realistic cognitions, and identifying and altering underlying beliefs and assumptions that predispose one to misapprehend reality (Dobson & Dozois, 2001). MBCT uses the strong degree of compatibility between CBT's approach and many of the techniques of cognitive training employed by early Buddhism. Comparisons with CBT are also pertinent if one considers the significance placed on self-management, self-control and self-improvement by the Buddha, together with his emphasis on systematic training to counter (and ultimately uproot) a particular problem in order to live with ever greater degrees of calmness and ease in the world. MBCT seems to shift the nature of the training away from CBT's main characteristics toward something more in accord with a generic Buddhist perspective. MBCT demonstrates a pragmatic and liberal attitude toward adapting meditation techniques from a variety of sources, and utilizing these for its particular ends (Gilpin, 2008).

Although there are a number of diverse approaches to incorporating mindfulness into counseling (Baer, 2003), in general, clients are encouraged to practice nonjudgmental awareness in ways that may help them address their clinical concerns. The focus is on merely observing persistently changing internal thoughts, feelings, and sensations along with noticing external stimuli. Mindfulness interventions focus on altering the impact of and response to, thoughts and feelings, and are regarded as particularly effective for conditions where intolerance of negative

affect and subsequent behavioral avoidance play a major role (Bishop, et al., 2004). In addition, the role of mindfulness in disengaging from unhealthy behavior patterns and helping to foster more adaptive strategies is thought to be significant in developing effective coping strategies (Kabat-Zinn, Massion, Hebert, & Rosenbaum, 1998). Examples of conditions where mindfulness interventions have been used include chronic pain, stress, anxiety, depression, borderline personality disorders, panic attacks, and eating disorders (Baer, 2003). Baer (2003) provided a comprehensive empirical and conceptual review of mindfulness-based clinical interventions. She concluded that despite some methodological weaknesses, the intervention review suggested that mindfulness-based interventions may help to alleviate a variety of mental health problems and improve psychological functioning. A meta-analysis of 20 MBSR studies led to similar conclusions (Grossman, Niemann, & Schmidt, 2004).

Bulimia Nervosa, Anorexia Nervosa, and Binge Eating Disorder Defined

The essential features of *bulimia nervosa* are binge eating and using purging methods to prevent weight gain. Also, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight. Bulimia nervosa usually begins in late adolescence or early adult life (*Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. text rev; *DSM-IV-TR*; American Psychiatric Association, 2000). Individuals with bulimia nervosa experience a lack of control over their eating during the episode, including the feeling either that one cannot stop eating, control how much one is eating, or control the type of foods eaten. Prevalence estimates for bulimia nervosa vary from 1-3% for women and 0.3% for men (*DSM-IV-TR*; American Psychiatric Association, 2000) to 11-13% in college populations (Coric & Murstein, 1995).

The essential features of *anorexia nervosa* are that the individual is extremely afraid of gaining weight, maintains a body weight that is below a minimally normal level for age and height and refuses to gain weight, and shows a significant disturbance in the perception of size or shape of his or her body. Anorexia Nervosa typically starts in mid- to late-adolescence (age 14-18 years; *DSM-IV-TR*; American Psychiatric Association, 2000). Prevalence estimates for anorexia nervosa among the general population is reported to be between 0.5% and 1.0% (*DSM-IV-TR*; American Psychiatric Association, 2000), and it is believed to be higher among college and high school populations (Mintz & Betz, 1988). Approximately 90% of the cases are female.

Binge eating disorder is currently number six under the classification “An Eating Disorder Not Otherwise Specified.” In recent years, it has gotten more notice. Binge eating disorder does not normally involve purging methods after bingeing. Some inappropriate purging behavior may occur occasionally, but it is not regularly used to offset the effects of the binge eating. Binge eating typically begins in late adolescence or in the early 20s, often coming soon after significant weight loss from dieting (*DSM-IV-TR*; American Psychiatric Association, 2000). An episode of binge eating is characterized by eating, within a 2-hour period of time, an amount of food that is definitely larger than most people would eat during a similar period of time in similar circumstances. This disorder afflicts approximately 5-10% of the general population (Grilo, 2002). It is more common among women (ratio of 3:2)

Certain personality traits and thinking styles are found more frequently in people with eating disorders as compared to the general population. Those with anorexia are clinically described as being obsessive and rigid, showing emotional restraint, preferring the familiar, having a high need for approval, and showing poor adaptability to change (Casper, Hedeker, &

McClough, 1992). The psychological dimensions underlying these clinical features are a triad of personality features: low novelty seeking, avoidance of harm, and reward dependence (Strober, Freeman, & Morrell, 1997).

Those with bulimia exhibit somewhat different personality characteristics involving poor impulse control, mood swings, and obsessive-compulsive behaviors (Aragona & Vella, 1998). Specific phobias, agoraphobia, panic disorder, generalized anxiety disorder, and alcohol dependence were all more elevated among bulimic individuals than among nonbulimic community members (Garfinkel et al., 1995).

Those with binge eating disorder tend to experience self-loathing, disgust about body size, depression, anxiety, somatic concerns, and interpersonal sensitivity at much higher rates than the typical person (*DSM-IV-TR*; American Psychiatric Association, 2000). Stress is also an important contributor (Kessler, 2009). Human and animal studies show increased eating as a common response to mild, chronic stress. The more frequently a person eats something in response to unpleasant emotions, the more likely this action is to become a habit. In an environment where food, particularly snack food, is always available, this person learns to equate eating with stress relief. Kessler (2009) referred to this as a “spiral of wanting.” Shame is also a common underlying issue for individuals with binge eating disorder. Secrecy is vital to conceal the act of overeating because it is difficult to acknowledge the overwhelming loss of control (Giordano, 2005).

Eating disorders are almost always accompanied by other disorders. Community samples, in which adolescents are randomly selected and interviewed for psychiatric disorders, revealed that about 90% of those fitting the criteria for an eating disorder also have other Axis I disorders, usually anxiety, depression, or Obsessive Compulsive Disorder (Lewinsohn, Striegel-Moore, & Seeley, 2000). Researchers have focused on personality characteristics such as rigidity, perfectionism, or neuroticism that may be a common link among these disorders (Podar, Hannus & Allik, 1999).

Individuals who score high on perfectionism and also perceive themselves as being overweight have a greater risk of bulimic symptoms (Joiner, Heatherton, Rudd, & Schmidt, 1997). A discrepancy between one’s actual self (perceived weight) and ideal self (a strive toward perfectionism) increases the likelihood of eating problems, especially among women. High perfectionism has been linked to high levels of disordered eating in a group of early adolescent females (McVey, Pepler, Davis, Flett, & Abdoell, 2002).

It is important to note that eating disorders usually cannot be treated by only one provider using one approach. A common approach to treatment is to use the treatment team approach. This team is usually comprised of a nutritionist, psychiatrist, physician and a counseling practitioner. Using mindfulness approaches is just one of many promising treatments to help treat the complexity of eating disorders.

Role of Mindfulness in Treatment of Eating Disorders

Mindfulness based clinical interventions appear to be a logical treatment choice for eating disordered clients and the common personality traits clients share. Women with bulimia nervosa and anorexia nervosa tend to struggle with issues of perfection, control, and extremely harsh self-criticism (Richards, Hardman, & Berrett, 2007). The intentions behind MBSR can offer an alternative lifestyle approach.

Proux (2008) conducted a study with six college-age women with bulimia nervosa who had experienced eating disordered symptoms for many years. The women in the study did experience comorbid mood (depression) or anxiety disorders and some were taking psychotropic medications. These women participated in a Mindfulness-Based Eating Disorder Treatment Group (M-BED Group) for eight, 2-hour sessions. Each session contained four components: experiential meditation practice, psychoeducation, discussion, and assigned home practice. For the six women participants, the core experience of the M-BED group involved a journey that began from self-hate, totally disconnected, idealized, objectified image of self to a relationship with the self that was gentler, kinder, and more authentic.

As Proux noted in the 2008 study, depression and anxiety are commonly associated with eating disorders. Those with binge eating disorder also struggle with depression and anxiety (*DSM-IV-TR*; American Psychiatric Association, 2000). In looking at the mechanisms of MBSR, it has been suggested that mindfulness may have an effect on two classes of cognitive operations: attention regulation and the adoption of an accepting attitude (Bishop, 2002).

Attention regulation is the mental training of one's mind to remain present-focused. As one practices meditation, thoughts frequently wander away from the present moment and thereafter are redirected gently to the targets of meditation. Those targets could be thoughts, emotions, somatic sensations, or environmental stimulation (Kabat-Zinn, 1990). Eating disordered individuals often have obsessive negative oriented thoughts that are ever present in their minds. "I am ugly," "I hate myself," "I am unlovable," "I am a failure," "my body disgusts me," or "I am fat," are common thoughts. These ruminating thoughts are so overpowering that they control actions, beliefs, thoughts, and emotions and block out the present moment. As mentioned earlier, 90% or those fitting the criteria for an eating disorder also have other Axis I disorders, including Obsessive Compulsive Disorder (Lewinsohn et al., 2000).

Karoly (1999) implied that high-functioning people are able to redirect their attentions to their goals after a failure episode without ruminating about the reasons for the failures. Empirical evidence documents that mindfulness meditation enhances emotional regulatory skills (Hamilton, Kitzman, & Guyotte, 2006). Other studies of attention process and emotion regulation indicate that effortful attention direction (flexible disengagement) is a key determinant to well-being (Baumeister, Hetherington, & Tice, 1994) through its effect on emotional regulation and self-regulatory behavior (Thayer, Friedman, & Borkovec, 1996). The observation of emotion during meditation may enhance the meditation practitioner's familiarity with her/his emotions and increase tolerance of negative emotions, which, in turn, reduce the magnitude and duration of unpleasant emotions. Beginning mindfulness practitioners are instructed to deliberately redirect attention to the sensations of respiration (chosen mental object—neutral stimulus) in the face of distressing thoughts, sensations, or emotions. In a 4-year follow-up study by Kabat-Zinn, Lipworth, Burney, and Sellers (1987), the most commonly used skill nearly all participants reported using was redirection of the attention to the breath. Seventy-eight percent to 90% (depending on time since participation) reported using this redirection of attention to the breath to some extent in their daily life situations, and 74% to 94% of all respondents reported it to be moderately or very useful in coping successfully with stressful situations. In exit interviews with participants in a pilot study of MBSR for women with severe hot flashes, most women reported using the redirection of attention to the breath to help them cope with their hot flashes and in this way developing a greater sense of control and confidence in dealing with them (Carmody, Crawford, & Churchill, 2006).

Breath sensations have the added clinical utility of being immediately and continually available to clients in everyday life. With practice, the client becomes more aware of which mind objects attention is drawn to from moment to moment and, instead of passively allowing the prior conditioned automatic cycle of association, deliberately redirects attention to the sensations of breathing. This redirection is repeated as attention invariably wanders away from the breath (Carmody, 2009). For clients with bulimia nervosa, the urge/impulse to purge can be overpowering. For clients with anorexia nervosa, the rigidity, drive toward perfectionism, and poor adaptability to change can be ever present. Practicing this simple technique has the promise of redirecting attention away from the urges and impulses. For clients with binge eating disorder, the urge to “stuff” in reaction to stress can be overpowering. Again, these clients can redirect attention to their breath until the overpowering urges have lessened or gone away completely. The redirection of attention also means less emotional reactivity to the symptoms in the midst of other activities, and a greater sense of control and confidence in dealing with distress can develop.

Empirical evidence has been provided that mindfulness is effective because it produces changes in metacognitions related to emotions and autobiographical memories (Teasdale et al., 2000). This suggests that mindfulness may help people maintain distance from their emotions. For example, following mindfulness training, formerly depressed people were able to describe past negative events in ways that suggested that they were able to maintain some distance from their emotions, recognize the effects of emotions on their cognitive process, and question the accuracy of their initial negative appraisals. Teasdale and colleagues (2000) theorized that learning to provide bare attention to thoughts and emotions was related to metacognitive changes. Mindfulness practitioners may be better able to tolerate mood downturns without becoming depressed because they are able to maintain “distance” from their thoughts and emotions. This ability to maintain “distance” from thoughts and emotions holds much hope for eating disorder clients that also struggle with depression.

The discipline of meditation also involves adopting a “nonstriving” attitude, also called acceptance (Kabat-Zinn, 1990), or detachment (Levine, 2000). This attitude stands in contrast to both the Western medical ethic and the psychological ethic that enhanced quality of life requires change (Baer, 2003). Whereas change often does accompany the practice of mindfulness, it is not because undesirable emotions or conditions are “pushed away,” but rather because people learn to live with and accept their physical and psychological limitations (Hamilton et al., 2006).

This degree of awareness requires an effort to be both present and nonjudgmental in the current moment. Clients are encouraged to practice nonjudgmental awareness in ways that may help address clinical concerns. Mindfulness meditation encourages clients not to judge or evaluate the veracity of a thought, but merely to observe it and to set it aside. With practice, clients learn that thoughts, emotions, and feelings such as pain are transient, do not necessarily reflect reality, and pass through consciousness rapidly (Hamilton, et al., 2006). As McVey et al. (2002) stated, a discrepancy between one’s actual self (perceived weight) and ideal self (a strive toward perfectionism) increases the likelihood of eating problems. Eating disordered clients could benefit a great deal knowing and accepting that their emotions, feelings, and thoughts do not necessarily reflect reality and that when those clients allow their emotions, feelings, and thoughts to pass through consciousness without judgment, the healing can begin.

The attitude of acceptance applies to negative life events in addition to thoughts, feelings, and emotions. Thoughts and feelings, even unpleasant ones, are a natural and healthy part of life

(Hanh, 1993). By learning to recognize and acknowledge negative emotions and feelings, clients can avoid being overwhelmed by even strong emotions:

Experiencing the pain in my body, I breathe in. Smiling at the pain in my body, I breathe out. Recognizing that this is a physical pain, I breathe in. Knowing that this is no more than a physical pain, I breathe out. (Hanh, 1993, p. 70)

A Closer Look at Using CBT With Mindfulness

In Cognitive Behavioral Therapy (CBT) alone, clients are encouraged to identify and change unhelpful or “irrational” thoughts. For example, in treating eating disordered clients, clients actively practice reframing their thoughts through repetition and practice. One might have a constant self voice that is telling them “I am a failure.” The pure CBT approach would have the client reframe “I am a failure” to “I am human and I make mistakes. I also have strengths.” The client could be asked to write those strengths on a piece of paper and read the list aloud every day. Goals of CBT include: (1) identify situations, people, feelings, or events that trigger eating disordered behavior (self-monitoring); (2) cognitively restructure the client’s irrational beliefs about body image, food, weight gain, and nutrition; (3) establish a schedule of regular eating and use alternative behaviors to substitute for unhealthy eating behaviors; (4) encourage the client to improve the variety of foods he/she eats by incorporating more forbidden foods into her/his meal plan; (5) use constructive problem-solving when negative emotions arise; and (6) prevent relapses (Erk, 2004). This CBT approach focuses on the cognitive-behavioral link.

The most comprehensively researched theoretical model for individuals with Binge Eating Disorder (BED) is CBT. The first goal in treatment is to normalize eating followed by a focus on identifying and reframing maladaptive beliefs. CBT reduces binge eating and psychopathology, and increases self esteem for BED clients (Levine & Marcus, 2003).

When CBT is combined with the mindfulness approach, clients are encouraged to merely observe their thoughts and then return attention to the task at hand, whatever that task happens to be (Kabat-Zinn, 1990). Dialectical behavioral therapy (DBT) is based on this combination of CBT and mindfulness. Although DBT was originally developed for individuals with borderline personality disorder, adaptations have been done to focus on BED with DBT principles. Levine and Marcus (2003) reported that DBT decreases binge eating and decreases maladaptive attitudes towards eating, shape, and weight.

In addition to working with thoughts, the need for an approach that addresses emotional factors in the eating disorders has begun to be identified in recent years, as a result of the need to improve on the outcomes of CBT for eating disorders (Fairburn & Harrison, 2003). Fairburn, Cooper, and Shafran (2003) also have looked at the role of mood intolerance in eating disorders. Their extended version of CBT includes a module on emotional regulation to be applied when there are clear difficulties in mood tolerance that are related to the individual’s eating cognitions and behaviors.

Role of Mindfulness in CEBT-ED

Cognitive Emotional Behavioral Therapy for eating disorders (CEBT-ED) is aimed at helping clients with eating disorders understand the experience and expression of emotions, so they can identify and challenge their beliefs and attend and respond to their emotions adaptively. Such skills are needed to reduce the need for maladaptive emotional coping behaviors. This approach draws upon a range of models and techniques, including cognitive behavioral therapy, dialectical behavioral therapy, mindfulness training, and experiential work (Corstorphine, 2006). CEBT-ED offers the clinician and client an alternative when standard CBT is unsuccessful in

relieving symptoms. The experiential component and elements of mindfulness training create an additional dimension to treatment, offering both the client and clinician the opportunity for creativity and self-exploration.

Since eating disordered clients' relationships with food are often infused with obsessive thoughts, anxiety, self-loathing and maladaptive coping processes, the behaviors of eating and not eating are symptoms of these and other psychological issues. On the road to healing, clients can be helped to deal with meals by having them practice the here-and-now mindfulness about the process of eating meals—being present with all their feelings, especially the pleasant sensations the body is set up to perceive when hunger is satisfied, and the social interaction that is real, not mechanical (Andersen, 2007). The mindful eating is being present, moment by moment, for each sensation that happens during eating, such as chewing, tasting and swallowing. Simple first steps toward introducing mindfulness while eating include:

- Eat sitting down
- Try to make the meal last at least 20 minutes
- Eat without TV, newspaper or computer
- Eat with your non-dominant hand
- Chew your food 30 to 50 times per bite
- Eat with chopsticks (Institute for Natural Resources, 2010)

Conclusion

Starting in the 1970s, many psychological interventions have involved the integration of Eastern and Western philosophies. Since the introduction of mindfulness into clinical settings, a large number of studies have documented its beneficial effect on psychological distress and well-being (Grossman et al., 2004; Shigaki et al., 2006). Baer (2003) stated that there are examples of conditions where mindfulness interventions have been used: chronic pain, stress, anxiety, depression, borderline personality disorders, panic attack, and eating disorders. Many eating disordered clients also experience stress, anxiety, and depression (*DSM-IV-TR*; American Psychiatric Association, 2000; Garfinkel et al., 1995; Kessler, 2009; Lewinsohn et al., 2000; Proux, 2008). Through a comprehensive empirical and conceptual review of mindfulness-based clinical interventions, Baer concluded that mindfulness-based interventions may help to alleviate a variety of mental health problems.

There are not a lot of research studies on the specific benefits for using mindfulness as a treatment component for the following eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder. Those that have been discussed in this article have shown great promise for using mindfulness as part of the treatment paradigm. Since many with eating disorders tend to struggle with issues of perfection, control, extremely harsh self-criticism, depression, and anxiety, the gentle, compassionate approach behind mindfulness treatments offers an alternative lifestyle approach that becomes a lifelong practice unique to each person (Proux, 2008).

References

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington, DC: Author. doi: 10.1176/appi.books.9780890423340

- Andersen, A. (2007). Stories I tell my patients: Where are you when you are eating? *Eating Disorders*, 15, 279-280. doi: 10.1080/10640260701323557
- Aragona, M., & Vella, G. (1998). Psychopathological considerations on the relationship between bulimia and obsessive-compulsive disorder. *Psychopathology*, 31, 197-205. doi:10.1159/000029040
- Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10, 125-143. doi: 10.1093/clipsy.bpg015
- Baumeister, R., Heatherton, T. F., & Tice, D. M. (1994). *Losing control: How and why people fail at self-regulation*. San Diego, CA: Academic Press.
- Bishop, S. R. (2002). What do we really know about mindfulness-based stress reduction. *Psychosomatic Medicine*, 64, 71-84.
- Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., Segal, Z. V., Abbey, S., Specia, M., Velting, D., & Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, 11(3). Retrieved from <http://www.clipsy.oupjournals.org/cgi/content/full/11/3/230>. doi: 10.1093/clips.bph077
- Carmody, J. (2009). Evolving conceptions of mindfulness in clinical settings. *Journal of Cognitive Psychotherapy: An International Quarterly*, 23(3), 270-280.
- Carmody, J., Crawford, S., & Churchill, L. (2006). A pilot study of mindfulness-based stress reduction for hot flashes. *Menopause*, 13(5), 760-769. doi: 10.1097/01.gme.0000227402.98933.d0
- Casper, R., Hedeker, D., & McClough, J. F. (1992). Personality dimensions in eating disorders and their relevance for subtyping. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31, 830-840. doi: 10.1097/00004583-199209000-00008
- Coric, C., & Murstein, B. I. (1995). Bulimia nervosa: Prevalence and psychological correlates in a college community. *Eating Disorders*, 1, 39-51.
- Corstorphine, E. (2006). Cognitive-emotional-behavioural therapy for the eating disorders: Working with beliefs about emotions. *European Eating Disorders Review*, 14, 448-461. doi: 10.1002/erv.747
- Dobson, K., & Dozois, D. (2001). Historical and philosophical bases of the cognitive-behavioral therapies. In K. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (pp. 3-39). New York, NY: Guilford Press.
- Erk, R.R. (2004). *Counseling treatments for children and adolescents with DSM-IV-TR disorders*. Upper Saddle River, NJ: Merrill Prentice Hall.
- Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. *The Lancet*, 361, 407-416. doi:10.1016/S0140-6736(03)12378-1
- Fairburn, G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy*, 41, 509-528. doi: 10.1016/S0005-7967(02)00088-8
- Garfinkel, P.E., Lin, E., Georgin, P., Spegg, C., Goldbloom, D. S., Kennedy, S., Kaplan, A. S., & Woodside, D. B. (1995). Bulimia nervosa in a Canadian community sample: Prevalence and comparison of subgroups. *American Journal of Psychiatry*, 152, 1052-1058.
- Gilpin, R. (2008). The use of Theravada Buddhist practices and perspectives in mindfulness-based cognitive therapy. *Contemporary Buddhism*, 9(2), 231-251. doi: 10.1080/14639940802556560

- Giordano, S. (2005). *Understanding eating disorders: Conceptual and ethical issues in the treatment of anorexia and bulimia nervosa*. Oxford, UK: Oxford University Press.
- Grilo, C. M. (2002). Binge eating disorder. In C. G. Fairburn & K. D. Brownell (Eds.), *Eating disorders and obesity* (pp.178-182). New York, NY: Guilford Press.
- Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, 57(1), 35-43. doi: 10.1016/S0022-3999(03)00573-7
- Hamilton, N. A., Kitzman, H., & Guyotte, S. (2006). Enhancing health and emotion: Mindfulness as a missing link between cognitive therapy and positive psychology. *Journal of Cognitive Psychotherapy: An International Quarterly*, 20(2), 123-134.
- Hanh, T. N. (1993). *The blooming of a lotus: Guided meditation exercises for healing and transformation*. (Annabel Laity, Trans.) Boston, MA: Beacon Press.
- Institute for Natural Resources. (2010). *Food addictions, overeating & mood swings*. CA: INR.
- Joiner, T. E., Heatherton, T. F., Rudd, M. D. & Schmidt, N. B. (1997). Perfectionism, perceived weight status, and bulimic symptoms: Two studies testing a diathesis-stress model. *Journal of Abnormal Psychology*, 106, 145-153. doi: 10.1037/0021-843X.106.1.145
- Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry*, 4, 33-47. doi: 10.1016/0163-8343(82)90026-3
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Delacorte.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. *Clinical Psychology Science Practice*, 10, 144-156.
- Kabat-Zinn, J., Lipworth, L., Burney, R., & Sellers, W. (1987). Four-year follow up of a meditation-based program for the self-regulation of chronic pain: Treatment outcome and compliance. *Clinical Journal of Pain*, 2, 159-173.
- Karoly, P. (1999). A goal-systems-self-regulatory perspective on personality, psychopathology, and change. *Review of General Psychology*, 3, 264-291. doi: 10.1037/1089-2680.3.4.264
- Kessler, D. A. (2009). *The end of overeating: Taking control of the insatiable American appetite*. New York, NY: Rodale.
- Levine, M. (2000). *The positive psychology of Buddhism and yoga: Paths to a mature happiness*. Mahwah, NJ: Lawrence Erlbaum.
- Levine, M. P., & Marcus, M. D. (2003). Psychosocial treatment of binge eating disorder: An update. *Eating Disorder Review*, 14(4).
- Lewinsohn, P., Striegel-Moore, R., & Seeley, J. (2000). Epidemiology and natural course of eating disorders in young women from adolescence to young adulthood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 1284-1292. doi: 10.1097/00004583-2000010000-00016
- McVey, G. L., Pepler, D., Davis, R., Flett, G. & Abdoell, M. (2002). Risk and protective factors associated with disordered eating during early adolescence. *Journal of Early Adolescence*, 22, 76-96.
- Mintz, L. B., & Betz, N. E. (1988). Prevalence and correlates of eating disordered behavior among college women. *Journal of Counseling Psychology*, 35, 463-471. doi: 10.1037/0022-016735.4.463

- Podar, I., Hannus, A., & Allik, J. (1999). Personality and affectivity characteristics associated with eating disorders: A comparison of eating disordered, weight-preoccupied, and normal samples. *Journal of Personality Assessment*, 73, 133-147. doi: 10.1207/S15327752JPA730109
- Proux, K. (2008). Experiences of women with Bulimia Nervosa in a mindfulness-based eating disorder treatment group (2008). *Eating Disorders*, 16, 52-72. doi: 10.1080/10640260701773496
- Rapgay, L., & Bystrisky, A. (2009). Classical mindfulness: An introduction to its theory and practice for clinical application. *Longevity, Regeneration, and Optimal Health*, 148-162. doi: 10.1111/j.1749-6632.2009.04405.x
- Richards, P. S., Hardman, R. K., & Berrett, M. E. (2007). *Spiritual approaches in the treatment of women with eating disorders*. Washington, DC: American Psychological Association. doi: 10.1037/11489-000
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York, NY: Guilford. doi: 10.1001/archgenpsychiatry.2010.168
- Shigaki, C., Glass, B., & Schopp, L. (2006). Mindfulness-based stress reduction in medical settings. *Journal of Clinical Psychology in Medical Settings*, 13(3), 209-216. doi: 10.1007/S10880-006-9033-8
- Strober, M., Freeman, R., & Morrell, W. (1997). The long-term course of severe Anorexia Nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. *International Journal of Eating Disorders*, 22, 359-360. doi: 10.1002/(SICI)1098-108X(199712)22:4<339::AID-EAT1>3.3.CO;2-H
- Teasdale, J. D., Segal, Z. V., Williams, J. M., Ridgeway, V. A., Soulsby, J. M. & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 614-623.
- Thayer, J. A., Friedman, B. H., & Borkovec, T. D. (1996). Autonomic characteristics of generalized anxiety disorder and worry. *Society of Behavioral Psychiatry*, 39, 255-266.

Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm