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PERSPECTIVES FROM THE FIELD

PERSPECTIVES FROM THE FIELD is a special feature included in this issue of the Journal of Creativity in Mental Health that provides mental health professionals with an opportunity to discuss their positions on a variety of creativity-related topics.

In this issue, authors share two different perspectives on conceptualization of and treatment approaches to clients with eating disorders. Veronica Lac, Erin Marble, and Ioana Boie discuss the creative relational approach of Gestalt-informed equine-assisted psychotherapy. Jonathan Matusitz and Jacqueline Martin explore the role of self-determination theory in the development and maintenance of disordered eating and distorted body image, and discuss how mental health professionals can offer effective treatment. Both perspectives offer unique insights into the conceptualization and treatment of eating disorders.

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Equine-Assisted Psychotherapy as a Creative Relational Approach to Treating Clients With Eating Disorders

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The increased prevalence of reported eating disorders, in conjunction with their potentially fatal consequences, is a current mental health concern. Development and maintenance of body image, weight, and concerns around eating often stem from individuals' various relational and cultural environments. We provide a discussion of Gestalt equine-assisted psychotherapy as a creative relational approach to eating disorder treatment and introduce a case example that illustrates the use and benefits of equine-assisted therapy with clients who have an eating disorder. A brief overview of the Diagnostic and Statistical Manual of Mental Disorders-*Fifth Edition diagnostic terms and criteria is also included.*

KEYWORDS eating disorders, equine-assisted psychotherapy, Gestalt, creativity

Eating disorders in young women and men have been an increasing concern in the mental health field. Anorexia nervosa (AN) is estimated to affect 0.2% to 3.7% of young women and approximately 1% of men (American Psychiatric Association [APA], 2006; Lucas, Beard, O'Fallon, & Kurland, 1991). Bulimia nervosa (BN) has an estimated prevalence of 1% to 2% in young women and 0.5% in men (Hudson, Hiripi, Pope, & Kessler, 2007; Lucas et al.,

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1991). Previous researchers have estimated the prevalence of eating disorders not otherwise specified (EDNOS) to be as high as 14.6% for women (Hudson et al., 2007). More recently, researchers have found lifetime prevalence of EDNOS to be 4.78% in adolescents and 4.64% in adults (Le Grange, Swanson, Crow, & Merikangas, 2012). However, with the release of the *Diagnostic and Statistical Manual of Mental Disorders*-Fifth Edition (DSM-5; APA, 2013) and changes to diagnostic criteria, prevalence rates of various categories are also likely to change in the future. Additionally, eating disorders are oftentimes underreported and misdiagnosed, further skewing estimates of occurrence.

Eating disorders can lead to various other health complications, and when left untreated or not treated successfully, they can result in death. Some researchers have found that when the onset of AN occurs between the ages of 10 and 15 years old, it may result in a 25-year reduction in lifespan (Harbottle, Birmingham, & Sayani, 2008). In addition, eating disorders are deemed as the most lethal of psychiatric disorders, with standardized mortality ratios of 5.86 for AN, 1.93 for BN, and 1.92 for EDNOS. In a study by Arcelus, Mitchell, Wales, and Nielson (2011), one fifth of individuals with AN who died had committed suicide. The National Institute of Mental Health (U.S. Department of Health and Human Services, 2001) reported that the annual mortality rate of AN in adolescent girls is 12 times higher than the rest of the population.

Because of the high prevalence rates and high mortality rates compared with other mental health concerns, significant research efforts are focused on determining both the environmental and genetic influences that play an important role in the development of disordered eating during early adolescence (Racine, Root, Klump, & Bulik, 2011), which is the typical period of onset for eating disorders (Le Grange, 2011). Genetics appear to have a strong impact on disordered eating during late adolescence and early adulthood, with heritability estimates ranging from 34% to 65% (Racine et al., 2011).

Relationships are part of the environmental challenges and have a critical influence on the development and maintenance of body image, weight, and eating concerns (Ambwani & Strauss, 2007; Jackson, Weiss, Lunquist, & Soderlind, 2005; Morrison, Doss, & Perez, 2009). A relational approach to treatment of eating disorders may be beneficial due to the relational aspects that accompany disordered eating. Disordered eating behaviors often occur in secrecy, and individuals who have an eating disorder often report feeling isolated from others due to the belief that they will be perceived negatively (Broussard, 2005). Ambwani and Strauss (2007) particularly emphasized the bidirectional impact of romantic relationships due to body-image concerns specific to physical intimacy. Additionally, feminist perspectives on the etiology of eating disorders emphasize the contributions of gender roles and issues of power, privilege, and marginalization in the development and maintenance of mental health concerns (Eriksen & Kress, 2008; Trepal, Boie,

& Kress, 2012). We will discuss the use of creative interventions in addressing the relational component in the etiology of eating disorders.

DSM-5 EATING DISORDER CATEGORIES

The APA (2013) recognizes several categories of disordered eating within the DSM-5. Most commonly noted are AN, BN, binge-eating disorder (BED), and unspecified feeding and eating disorders (UFED). Due to the new diagnostic names and criteria in DSM-5, we have included brief descriptions of each.

Anorexia Nervosa

According the APA (2013), AN consists of three primary features, including persistent restriction of food intake; fear of gaining weight or being fat, or behavior that interferes with weight gain; and disturbance in self-perception of weight or body shape. Individuals with AN have a body weight lower than the minimum norm, or, in children and adolescents, body weight that does not meet developmental expectations (APA, 2013).

Bulimia Nervosa

BN consists of recurring instances of binge eating (i.e., eating an amount of food that is larger than what most others would eat in the same amount of time in a similar context and feeling out of control while doing so) and compensatory behaviors to prevent weight gain (i.e., laxatives, diuretics, self-induced vomiting, excessive exercise; APA, 2013). This cycle of binge eating and compensating occurs at least once a week for 3 months. Additionally, self-perception is overly influenced by weight and body shape (APA, 2013).

Binge-Eating Disorder

A recent addition to the DSM-5, BED is characterized by recurrent episodes of binge eating that are associated with (a) eating faster than usual; (b) eating until uncomfortably full; (c) eating large amounts of food without physical hunger; (d) eating alone due to embarrassment over quantity of food intake; or (e) feeling guilty, depressed, or disgusted (APA, 2013). Episodes occur at least once a week for 3 months and are not accompanied by compensatory behaviors to avoid weight gain. An individual with BED experiences distress regarding their episodes of binge eating (APA, 2013).

Unspecified Feeding and Eating Disorders

According to the APA (2013), the UFED category applies to the presentation of symptoms that do not meet the necessary diagnostic criteria for the other disorders. This category was previously termed eating disorders not otherwise specified (EDNOS) in the DSM- Fourth Edition, Text Revision (APA, 2000). However, the symptoms that are present cause significant stress or impaired functioning in social, occupational, or other areas of life. If the clinician has more information or the symptomatology is similar to a particular disorder but does not fulfill diagnostic criteria, they may choose to use the diagnosis of other specified feeding or eating disorder, which allows for greater specification (APA, 2013).

TREATMENT OPTIONS

Eating disorders pose specific challenges for treatment providers, and early interventions are essential, especially to prevent the development of chronic patterns that may be more difficult to treat (Le Grange & Loeb, 2007). Just as for any other form of psychotherapy, treatment can be tailored to the client for the best likelihood of success.

Treatment for eating disorders has to address one or more of the three categories of etiological factors contributing to eating disorders: biological, psychological, and sociocultural. With most of the current treatment approaches aimed at addressing the biological and psychological components, it is important to be cognizant of the relational and cultural contributors to the development of eating disorders and to address them in treatment.

Common interventions for eating disorders include inpatient programs and intensive outpatient programs with an emphasis on individual therapy. Some of the most popular approaches include cognitive-behavioral therapy (Campbell & Schmidt, 2011) and dialectical behavioral therapy (Linehan & Chen, 2005). Other supportive approaches are family-based treatment (Eisler et al., 1997; Le Grange, 2011; Lock et al., 2010; Treasure & Russell, 2011) and group work (Tantillo, Bitter, & Adams, 2001). More recently, due to the moderate effectiveness of traditional approaches, other innovative and creative treatment interventions include cinematherapy (Gramaglia et al., 2011), music therapy (Hilliard, 2001; Lejonclou & Trondalen, 2009), art therapy (Diamond-Raab & Orrell-Valente, 2002; Ki, 2011), and movement or yoga therapy (Carei, Fyfe-Johnson, Breuner, & Brown, 2010; Scime & Cook-Cottone, 2008). These creative components can often be found woven into the more traditional treatment programs and can be practiced independently. Viewing the development and treatment of eating disorders within a relational context is an additional approach to treatment that may be beneficial for clients.

Relational Approaches to Treatment

Relational approaches, such as interpersonal psychotherapy (Fairburn et al., 1991; Wilfley, MacKenzie, Welch, Ayres, & Weissmann, 2000), dialectical behavior therapy (Safer, Robinson, & Jo, 2010; Safer, Telch, & Agras, 2001), Gestalt psychotherapy (Angermann, 1998; Meyer, 1991), and relational-cultural therapy (Sanftner, Tantillo, & Seidlitz, 2004; Tantillo, MacDowell, Anson, Taillie, & Cole, 2009; Trepal et al., 2012), as well as family therapeutic approaches, recognize the influence of relationships on the development and maintenance of eating disorders. The premise is that a client does not develop an eating disorder in isolation, and eating disorders are influenced and can be maintained by unhealthy relationships and relational patterns. Conversely, relationships can also provide a significant amount of support in the process of recovery from an eating disorder. Lastly, healthy relational skills and healthy relationships can benefit the client's long-lasting recovery goals.

Of the creative and relational approaches, equine-assisted interventions have been recently established in the field of eating disorders treatment. Literature on this topic is very scarce and provides little evidence of equine-assisted psychotherapy (EAP) with clients with eating disorders (Christian, 2005; Lutter, 2008; Marx & Cumella, 2003). Many of the treatment centers have been utilizing equine-assisted interventions of various degrees and from different theoretical perspectives, including EAP (The Prosperity Eating Disorders and Wellness Center, 2013; Remuda Ranch, 2013; Selah House, 2013; Timberline Knolls, 2013).

Gestalt psychotherapy

Gestalt psychotherapy takes an existential, holistic, and relational stance to the therapeutic relationship. It is a process-driven therapy that allows for creativity, experimentation, and improvisation (Spagnuolo Lobb, 2003). Because some of the mechanisms involved in the development of eating disorders are based on this mind–body separation, eating disorders can be seen as a somatic disorder related to body alienation and the desensitization of emotions and physical sensations in the body. This manifests into the ability to ignore feelings of hunger and distorted perceptions of the body in AN or the inability to feel full in the case of BED. Gestalt psychotherapy can address two main processes involved in the development and maintenance of eating disorders, particularly (a) mind–body connection, and (b) relational processes.

Mind–body dichotomy. Clients with eating disorders oftentimes experience a mind–body dichotomy, where the client separates their body processes, including feelings, from their cognitions. When working to integrate the mind–body dichotomy, the counselor pays attention to the somatic process between the client and the counselor as it unfolds in each moment.

In Gestalt terms, somatization refers to the embodiment of our lived experience and the process by which we do that. Body process is a central element of Gestalt theory, believing in an absolute inseparable unity of bodily experience, language, thought, and behavior in and out of awareness (Clarkson & Mackewn, 1993). Fritz Perls (1976), the founder of Gestalt psychotherapy, emphasized that the mind–body split is an artificial one and that to focus on one without the other would be detrimental to healthy functioning.

Relational processes. The holistic approach to psychological well-being and focus on integration of mind and body gives rise to a change in relational processes. Additionally, it highlights the primary tenets within Gestalt practice, which include working in the present moment, without interpretation by the therapist, through focusing on increasing the client's awareness of the process by which they make or break connection with themselves and others.

According to Yontef (1993), awareness can be seen as the way individuals experience and interpret the here-and-now, their understanding of what they are doing, and how they are doing it. Furthermore, it is their knowledge that they are responsible for their actions and their choice of action. Sinay (1997, p. 89) defines it as "a deliberate consciousness about what is happening (physical sensations, feelings, imagination) 'to me' and what is happening in the environment I am integrated in."

Equine-Assisted Psychotherapy as a Relational Therapeutic Approach

The same two processes of relational processes and mind–body connection are addressed in the integration of Gestalt psychotherapy and equine psychotherapeutic work. Horses embody the principles of Gestalt. They live and breathe the concepts of here-and-now and embodied contact (Rector, 2005). First and foremost, they are herd animals. To survive, they must live in relationship and have an awareness of the impact of the way they make contact with each other and their environment. Horses are congruent in what they are feeling internally at all times and do not pretend to be something that they are not. They are authentic and relate to each other honestly and truthfully and embody their experiences (Rector, 2005). They naturally live in the here-and-now. They do not worry about what might happen next or what has happened in the past. This focus on the here-and-now becomes a particularly powerful way of relating to reality because many clients with eating disorders focus on the source of their anxiety in their inner worlds and oftentimes struggle to live their life authentically.

Whether through petting or grooming the horses, the soothing touch and contact with the horse will likely create a lasting impact on the client's experience. Physical touch is essential to life and relationships; it is a preverbal method of communication and "is such a direct and definitive

way of communicating 'body to body'" (Kepner, 1987, p. 72) that the quality of touch that occurs between the primary caregiver and the infant directly affects the neurological development of the child (Gerhardt, 2004; Stern, 1998). Working with horses allows for an even deeper embodied experience, particularly for clients who need to feel a physical sense of support.

Relational dimension of equine-assisted psychotherapy

When individuals work with horses, the horses naturally transfer their ways of being in the herd to being around us. Individuals, in turn, naturally mimic these acts of affection when they groom and pet the horses. Horses are prey animals and are naturally claustrophobic, skeptical of new things, and easily panicked (Parelli, 2011). When horses view people as safe, the connection and relationship between the horse and the human deepens (Natural Lifemanship, 2010). When individuals walk, lead, ride, and train with horses, they do so in relationship. The start of the relationship is coming into contact.

Horses, in particular, are highly attuned to human emotions and challenge individuals to stay congruent with their feelings when relating with them. In return, they offer individuals nonjudgmental, honest feedback and teach people to be more aware of the connections between mind, body, and emotions through breath and body sensations. This allows for the opportunity to make contact with the self and the environment and to relate to others in a different way.

The relational nature of horses can help facilitate the healing process for those suffering from eating disorders. With Gestalt EAP, the three key elements of Gestalt theory that are evident are those of *contact, relationship*, and *experiments*.

CASE EXAMPLE: SAMANTHA

To illustrate the concepts we have introduced, we will discuss how horses and Gestalt psychotherapy have impacted the therapeutic process in Samantha's case. Samantha is a 19-year-old Caucasian woman who was diagnosed with AN when she was 15 years old. Samantha is adopted, and has grown up in a family of five, with two older siblings. She referred to her family as her adoptive family and reported being in a relationship with her family "because she has to." She has presented with restrictive eating behaviors, and oftentimes, high anxiety, depression, and substance abuse. She currently has a boyfriend, but she reported not feeling very invested in the relationship and being more comfortable with previous long-distance relationships. During the therapeutic sessions, she described having experienced trauma as a child.

Contact, Relationship, and Experiments in Gestalt Equine-Assisted Psychotherapy

Contact

In the herd, horses make contact through all of their senses. They touch, smell, taste, see, and hear everything around them. They will mutually groom each other and breathe each other in. Horses will hang their heads around each other's necks and lean into one another. A mare and her foal can often be seen in this pose where the mother is resting her neck on her young to comfort and calm. Horses are curious by nature and, as herd animals, rely on their social dynamics and hierarchies to keep themselves safe from predators.

To explore contact, the therapist can invite Samantha to connect with a horse through paying attention to her breath by offering an experiment of standing belly to belly with the horse and breathing together. This simple experiment can allow Samantha to embody her sense of self in that moment of connection. The feeling of the warmth of the horse against her body and mindful breathing may facilitate a deepening of Samantha's emotional awareness of how she becomes anxious in the presence of intimacy and connection. By locating the experience of anxiety in an embodied way, Samantha can then begin to recognize these sensations within herself outside of the therapeutic space and empower herself to self-regulate. The horse in this experiment essentially provides an immediate biofeedback process, which the therapist can help Samantha to explore deeper.

To make contact with others, first individuals need to be in contact with themselves, which involves being mindful, present, centered, and grounded in the here-and-now present moment. Contact is something that happens between people, something that arises from the interaction. It is here that people discover their boundaries, both physically and emotionally. It is here that the individual discovers what is "me" and what is "not me." In Samantha's case, there is an apparent lack of contact with her family of origin, adoptive family, and her intimate relationships. In Gestalt therapy, clients are supported to raise their awareness of how they interrupt their contacting process, which inhibits their ability to live authentically in their relationships.

Relationship

In Samantha's case, the therapist may work on growing the relationships out of contact with the horses. Contact is the place within relationships where one's energetic, physical, emotional, and spiritual boundaries meet. Because Gestalt therapy is a relational process-driven therapy, it is this process of making and breaking contact that the therapist pays attention to in each moment. In Gestalt EAP, this means the way Samantha brings herself into the relationship with the horse or horses with which she is working, as well as

the therapeutic relationship. Samantha would be working on establishing a genuine relationship based on contact over time with the horse. Additionally, the therapist would encourage Samantha to pay attention to her feelings and her inner dialogue while she is in contact with the horse, as well as to act congruent to her feelings. This process enables a degree of authenticity that could later be translated into other relationships in Samantha's life.

The therapist may be able to first explore the extent of contact occurring by examining Samantha's relationship with the horse. Many of Samantha's patterns of communication may suggest the level of openness and trust with which she enters relationships. The therapist may explore those by asking nonjudgmental questions or observations about the interactions with the horse. Additionally, as the relationship progresses, the counselor can determine the level of intimacy with which Samantha is comfortable. This is particularly important in providing depth to a relationship over time.

Experiments

Creativity and experimentation are foundational elements of Gestalt therapy, where the Gestalt experiment "is a way of thinking out loud, a concretization of one's imagination, a creative adventure" (Zinker, 1977, p. 27). Gestalt EAP upholds the spirit of this tenet and views each moment of contact between the client and horse within the therapy session as an experiment for the client in how they co-create relationships, moments of intimacy, or distance, and how they project, deflect, or retroflect their feelings on a moment-by-moment basis. The horses provided immediate feedback to Samantha and her therapist in their here-and-now responses within the relationship. This process is powerful and authentic as it provides the opportunity to shed light on what is experienced in the moment, provide observations of the process, and try immediate different approaches.

The essence of experiments is to provide clients with a new awareness of how they interact with those around them. The therapeutic space allows them to test out new ways of being in a relationship. Experiments offer clients choices and allow them to actively and clearly take responsibility and ownership for the choices they make, which can then be transferred into their real life outside of the therapy space. Most importantly, in working with a horse, Samantha and her counselor can explore whether she builds healthy boundaries in relationships. Physical safety becomes paramount, even if the horse is trustworthy. These experiments can provide means of exploring how to build healthy and long-lasting boundaries in relationships.

Creativity and experiments are unique opportunities, not afforded by many therapeutic approaches, because of the experiential and relational nature of the Gestalt EAP. This brings clarity for the client that may not otherwise be as accessible. The creativity that horses can bring into the therapeutic encounter allows the therapy session to "become a series of small

experiential situations which are organically intertwined with each other, each event serving a particular function for the client and holding in it a potential surprise, a discovery totally unexpected by both client and therapist" (Zinker, 1977, p. 127). Gestalt therapy "seeks to bring the body back to life, back into a constantly shifting and growing capacity" (Totton, 2003, p. 107) so that clients can begin to engage with themselves and the world around them with more aliveness.

Acceptance without judgment is a rare quality among humans but is often found in the relationship with horses. This supportive quality allows the client to engage in experiencing differently the relationship with the horse and the therapist, as well as to experiment, explore, and not feel judged. This is a particular strength for this client because one of her biggest triggers has been friends' and family members' messages surrounding her body, eating patterns, and personality.

Overall, the therapeutic experience facilitated by the horses allows a client like Samantha to grow in contact with the horse and the counselor, to explore boundaries, trust, and intimacy within the relationship, and ultimately to engage in relationships outside of the therapeutic relationship in the same embodied and authentic manner.

IMPLICATIONS

Samantha has the opportunity to work on multiple facets of her relationships, communication patterns, and authentic living in the here-and-now as a result of being in the relationship with the horses. As mentioned earlier, many of these factors could contribute to the development and maintenance of the client's eating disorder. Employing EAP may provide a client with a powerful experiential modality to her recovery, which could be used in conjunction with other therapeutic approaches.

As counselors, it is important to remember the unique characteristics of each client and to employ creative ways to sustain recovery from eating disorders and fuel a healthy self-discovery. In addition, the counselor should monitor the client's progress to avoid harm and determine suitable treatments (American Counseling Association [ACA], 2005, Standards A.4.a, A.11.b, and B.5.a) and employ interventions that are appropriate in addressing specific client needs. Lastly, the counselor should ensure the boundaries of their competence (ACA, 2005, Standard C.2.a) and continue consulting with a multidisciplinary team of professionals to provide support for the client's medical, dietary, and psychiatric needs (ACA, 2005, Standard B.3.b). Although there is anecdotal evidence that equine-assisted interventions are helpful in supporting clients' recovery from an eating disorder (Christian, 2005; Marx & Cumella, 2003) and more eating disorder treatment centers around the country are employing them (Remuda Ranch, 2013), there

is a need for more research to determine the specific component of the effectiveness of EAP approaches with clients with eating disorders.

These are both ethical imperatives (ACA, 2005) and prerogatives of the Association for Creativity in Counseling. Lastly, as a counselor providing EAP services to clients, seeking the appropriate training, supervision, and consultation is crucial in ensuring the highest level of competence (ACA, 2005, Standards C.2.a and C.2.b).

CONCLUSIONS

In recognizing both the severity and uniqueness of the client's struggles with her or his eating disorder, it is important to consider different interventions to address the client's particular needs. These needs can vary greatly and may include building relational competence, growing in supportive, nonjudgmental, and honest relationships with the horse and their therapist, gaining a sense of their embodied presence, finding their authentic self, and living an authentic life. Through EAP, horses can provide the client recovering from eating disorders with a sense of renewed hope in relationships, in themselves, and in their recovery when EAP is used by itself or as a complementary intervention with other therapeutic approaches.

REFERENCES

Ambwani, S., & Strauss, J. (2007). Love thyself before loving others? A qualitative and quantitative analysis of gender differences in body image and romantic love. *Sex Roles*, *56*, 13–21.

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2006). *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium 2006*. Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Angermann, K. (1998). Gestalt therapy for eating disorders: An illustration. *Gestalt Journal*, *21*(1), 19–47.

Arcelus, J., Mitchell, A. J., Wales, J., & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, *68*, 724–731. doi:10.1001/archgenpsychiatry.2011.74

Broussard, B. B. (2005). Women's experiences of bulimia nervosa. *Journal of Advanced Nursing*, *49*, 43–50.

Campbell, M., & Schmidt, U. (2011). Cognitive-behavioral therapy for adolescent bulimia nervosa and binge-eating disorder. In D. Le Grange & J. Lock

(Eds.), *Eating disorders in children and adolescents: A clinical handbook* (pp. 305–318). New York, NY: Guilford.

Carei, T. R., Fyfe-Johnson, A. L., Breuner, C. C., & Brown, M. A. (2010). Randomized controlled clinical trial of yoga in the treatment of eating disorders. *Journal of Adolescent Health*, *46*, 346–351. doi:10.1016/j.jadohealth.2009.08.007

Christian, J. E. (2005). All creatures great and small: Utilizing equine-assisted therapy to treat eating disorders. *Journal of Psychology and Christianity*, *24*(1), 65–67.

Clarkson, P., & Mackewn, J. (1993). *Key figures in counselling and psychotherapy: Fritz Perls* (W. Dryden, Ed.).London, UK: Sage.

Diamond-Raab, L., & Orrell-Valente, J. K. (2002). Art therapy, psychodrama, and verbal therapy: An integrative model of group therapy in the treatment of adolescents with anorexia nervosa and bulimia nervosa. *Child and Adolescent Psychiatric Clinics of North America*, *11*, 343–364.

Eisler, I., Dare, C., Russell, G. F. M., Szmukler, G. I., Le Grange, D., & Dodge, L. (1997). Family and individual therapy for anorexia nervosa: A five-year follow-up. *Archives of General Psychiatry*, *54*, 1025–1030. doi:10.1001/archpsyc.1997.01830230063008

Eriksen, K., & Kress, V. E. (2008). Gender and diagnosis: Struggles and suggestions for counselors. *Journal of Counseling & Development*, *86*, 152–162.

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M.E., . . . Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry*, *48*, 463–469.

Gerhardt, S. (2004). *Why love matters: How affection shapes a baby's brain*. New York, NY: Routledge.

Gramaglia, C., Abbate-Daga, G., Amianto, F., Brustolin, A., Campisi, S., De-Bacco, C., & Fassino, S. (2011). Cinematherapy in the day hospital treatment of patients with eating disorders: Case study and clinical considerations. *The Arts in Psychotherapy*, *38*, 261–266. doi:10.1016/j.aip.2011.08.004

Harbottle, E. J., Birmingham, C. L., & Sayani, F. (2008). Anorexia nervosa: A survival analysis. *Eating and Weight Disorders*, *13*(2), e32–e34.

Hilliard, R. (2001). The use of cognitive-behavioral music therapy in the treatment of women with eating disorders. *Music Therapy Perspectives*, *19*, 109–113.

Hudson J. I., Hiripi, E., Pope, H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61*, 348–358. doi:10.1016/j.biopsych.2006.03.040

Jackson, T., Weiss, K. E., Lunquist, J. J., & Soderlind, A. (2005). Sociotropy and perceptions of interpersonal relationships as predictors of eating disturbances among college women: Two prospective studies. *The Journal of Genetic Psychology*, *166*, 346–359.

Kepner, J. I. (1987). *Body process: A Gestalt approach to working with the body in psychotherapy*. Cleveland, OH: Gestalt Institute of Cleveland Press.

Ki, P. (2011). Exploring the experiences of participants in short-term art-based support groups for adults living with eating disorders. *Canadian Art Therapy Association Journal*, *24*(2), 1–13.

Le Grange, D. (2011). Childhood and adolescence: Looking at eating disorders when they start. In D. Le Grange & J. Lock (Eds.), *Eating disorders in children and adolescents: A clinical handbook* (pp. 3–8). New York, NY: Guilford.

Le Grange, D., & Loeb, K. L. (2007). Early identification and treatment of eating disorders: Prodrome to syndrome. *Early Intervention in Psychiatry*, *1*, 27–39.

Le Grange, D., Swanson, S. A., Crow, S. J., & Merikangas, K. R. (2012). Eating disorder not otherwise specified presentation in the US population. *International Journal of Eating Disorders*, *45*, 711–718

Lejonclou, A., & Trondalen, G. (2009). 'I've started to move into my own body': Music therapy with women suffering from eating disorders. *Nordic Journal of Music Therapy*, *18*, 79–92. doi:10.1080/08098130802610924

Linehan, M. M., & Chen, E. Y. (2005). Dialectical behavior therapy for eating disorders. In A. Freeman, S. H. Felgoise, C. M. Nezu, A. M. Nezu, & M. A. Reinecke (Eds.), *Encyclopedia of cognitive behavioral therapy* (pp. 168–171). New York, NY: Springer.

Lock, J., Le Grange, D., Agras, S., Moye, A., Bryson, S. W., & Jo, B. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*, *67*, 1025–1032. doi:10.1001/archgenpsychiatry.2010.128

Lucas, A. R., Beard, C. M., O'Fallon, W. M., & Kurland, L. T. (1991). 50-year trends in the incidence of anorexia nervosa in Rochester, Minn.: A population-based study. *The American Journal of Psychiatry*, *148*, 917–922.

Lutter, C. B. (2008). *Equine assisted therapy and exercise with eating disorders: A retrospective chart review and mixed method analysis* (Unpublished doctoral dissertation). The University of Texas at Arlington,Arlington, TX.

Marx, R. D., & Cumella, E. J. (2003). Questions and answers. *Eating Disorders*, *11*, 143–147. doi:10.1080/10640260390199325

Meyer, L. (1991). Using Gestalt therapy in the treatment of anorexia nervosa. *British Review of Bulimia and Anorexia Nervosa*, *5*(1), 7–16.

Morrison, K. R., Doss, B. D., & Perez, M. (2009). Body image and disordered eating in romantic relationships. *Journal of Social and Clinical Psychology*, *28*, 281–306.

National Institute of Mental Health, U.S. Department of Health and Human Services. (2001). *The numbers count: Mental disorders in America*, 2001 (NIH Publ. No. 01–4584). Bethesda, MD: Author.

Natural Lifemanship (2010). The natural lifemanship model. Retrieved from http://naturallifemanship.com/?page_id=24

Parelli, P. (2011). *Why do horses pull back*. Retrieved from http://www.parellinaturalhorsetraining.com/horse-problems-why-do-horses-pull-back/

Perls, F. (1976). *The Gestalt approach, and eye witness to therapy*. New York, NY: Bantam.

Racine, S. E., Root, T. L., Klump, K. L., & Bulik, C. M. (2011). Environmental and genetic risk factors for eating disorders: A developmental perspective. In D. Le Grange & J. Lock (Eds.), *Eating disorders in children and adolescents: A clinical handbook* (pp. 25–33). New York, NY: Guilford.

Rector, B. K. (2005). *Adventures in awareness: Learning with the help of horses*. Bloomington, IN: AuthorHouse.

Remuda Ranch. (2013). *Equine therapy at Remuda Ranch*. Retrieved from https://www.remudaranch.com/about/tour-remuda-ranch/equine-therapy-at-remuda-ranch

Safer, D. L., Robinson, A. H., & Jo, B. (2010). Outcome from a randomized controlled trial of group therapy for binge eating disorder: Comparing dialectical behavior therapy adapted for binge eating to an active comparison group therapy. *Behavior Therapy*, *41*, 106–120. doi:10.1016/j.beth.2009.01.006

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry*, *158*, 632–634. doi:10.1176/appi.ajp.158.4.632

Sanftner, J. L., Tantillo, M., & Seidlitz, L. (2004). A pilot investigation of the relation of perceived mutuality to eating disorders in women. *Women & Health*, *39*, 85–100. doi:10.1300/J013v39n01_05

Scime, M., & Cook-Cottone, C. (2008). Primary prevention of eating disorders: A constructivist integration of mind and body strategies. *International Journal of Eating Disorders*, *41*, 134–142.

Selah House. (2013). *Equine therapy*. Retrieved from http://www.selahhouse.com/Programs/AdultTreatment/EquineTherapy

Sinay, S. (1997). *Gestalt for beginners*. New York, NY: Writers and Readers.

Spagnuolo Lobb, M. S. (2003). Therapeutic meeting as improvisational co-creation. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.), *Creative license: The art of Gestalt therapy* (pp. 37–49). Vienna, Austria: Springer.

Stern, D. N. (1998). *The interpersonal world of the infant*. London, England: Karnac.

Tantillo, M., Bitter, N., & Adams, B. (2001). Enhancing readiness for eating disorder change: A relational/motivational group model for change. *Eating Disorders: The Journal of Treatment & Prevention*, *9*, 203–216.

Tantillo, M., MacDowell, S., Anson, E., Taillie, E., & Cole, R. (2009). Combining supported housing and partial hospitalization to improve eating disorder symptoms, perceived health status, and health related quality of life for women with eating disorders. *Eating Disorders*, *17*, 385–399. doi:10.1080/10640260903210172

Timberline Knolls. (2013). *Equine therapy*. Retrieved from http://www.timberlineknolls.com/why/program/therapies/equine

The Prosperity Eating Disorders and Wellness Center. (2013). *Equine facilitated psychotherapy*. Retrieved from http://www.centerforhopeofnova.com/Equine-Therapy.html

Totton, N. (2003). *Body psychotherapy: An introduction*. Maidenhead, UK: Open University Press.

Treasure, J., & Russell, G. (2011). The case for early intervention in anorexia nervosa: Theoretical exploration of maintaining factors. *The British Journal of Psychiatry*, *199*, 5–7. doi:10.1192/bjp.bp.110.087585

Trepal, H. C., Boie, I., & Kress, V. E. (2012). A relational cultural approach to working with clients with eating disorders. *Journal of Counseling and Development*, *90*, 346–356.

Wilfley, D. E., MacKenzie, K. R., Welch, R. R., Ayres, V. E., & Weissman, M. M. (2000). *Interpersonal psychotherapy for group*. New York, NY: Basic.

Yontef, G. (1993). *Awareness, dialogue and process: Essays on Gestalt therapy*. Highland, NY: Gestalt Journal Publications.

Zinker, J. (1977). *Creative processes in Gestalt therapy*. New York, NY: Vintage.

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