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BODY EXPERIENCE, IDENTITY AND THE OTHER'S GAZE IN PERSONS WITH FEEDING AND EATING DISORDERS

abstract

The purpose of this paper is to define and describe the main phenomenological dimensions of the life-world of persons prone to Feeding and Eating Disorders (FEDs), within the framework of a model that considers abnormal eating behaviour an epiphenomenon of a more profound disorder of lived corporeality and identity. The core idea is that persons with FEDs experience their own body first and foremost as an object being looked at by another, rather than coenaesthetically or from a first-person perspective. Alienation from one's own body and the need to feel oneself only through the gaze of the others can be illuminated by looking at it in the light of the Sartrean concept of feeling a lived-body-for-others.

keywords

body experiences, body-for-others, feeding and eating disorders, identity, Sartre

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1. Introduction

Feeding and Eating disorders (FEDs) encompass three main diagnoses: anorexia nervosa, bulimia nervosa, and binge eating disorder. However, the collection of disturbances of eating attitudes and behaviours includes several other conditions such as pica, rumination disorder, purging disorder, atypical anorexia and bulimia nervosa, subthreshold binge eating disorder, and night eating syndrome.

Longitudinal studies indicate that most patients migrate among diagnoses over time (Fairburn, Cooper *et al.*, 2003; Milos *et al.*, 2005) without a substantial change in basic psychopathological features (Tozzi *et al.*, 2005; Fairburn and Cooper, 2007; Eddy *et al.*, 2008; Castellini, Lo Sauro, *et al.*, 2011) suggesting the existence of a common psychopathological core. Indeed, these disorders consist in abnormalities that are shown on two different domains, one behavioural and the other experiential.

Behavioral anomalies include binge eating, dietary restraint, compensatory purging, and body checking. Abnormal experiences include preoccupations with one's weight and shape and an anomalous perception of these. There is a general agreement on considering behavioral anomalies – which are required for DSM diagnosis – as secondary epiphenomena to a more basic psychopathological core, namely excessive concerns about body shape and weight.

In the DSM-5 (American Psychiatric Association, 2013), FEDs are characterized by severe disturbances in eating behaviour, but, as a matter of fact, the abnormal eating behaviour can be considered the epiphenomenon of different specific cognitive and emotional disturbances (Fairburn, Cooper *et al.*, 2003; Williamson *et al.*, 2004; Dalle Grave, 2011), including an overestimation of the shape and weight concerns and of the personal identity (Carter *et al.*, 2004; Loeb *et al.*, 2007; Ricca *et al.*, 2010). Persons affected by FEDs have a tendency to overvalue their body shape and weight (Fairburn and Harrison, 2003), and "tend to define themselves on the basis of their shape and weight and their ability to control them" (*ibidem*, p. 407) - whereas most people evaluate themselves on the basis of the way they perceive their performance in other domains, e.g. work, relationship, etc.

The present paper aims to overcome the simplistic behavioural assessment suggested by the DSM, and to provide a comprehensive description of the main psychopathological dimensions in the persons affected by FEDs - especially focusing on the subjective perception of their own body, and their personal identity. The basic idea is that FED patients can be better understood as suffering from *a specific disorder of lived corporeality contributing to an anomalous constitution of one's identity*. We believe that a comprehensive understanding of these dimensions can improve diagnosis and clinical approach to patients.

2. Lived body

FEDs are defined as behavioural disorders, whose psychiatric diagnosis is strictly based on abnormal eating behaviour. On the other hand, clinical reports show that these persons experience their body differently from other people. Since the beginning of the 20th century, phenomenology has developed a distinction between lived body (*Leib*) and physical body (*Koerper*), or between body-subject and body-object (see Husserl, 1912-1915a; b). The lived body is the coenaesthetic apprehension of one's own body, the primitive experience of oneself, the basic form of self-awareness, or direct, unmediated experience of one's own body, and not a representation of it mediated by reflection (as the case with body image) (Merleau-Ponty, 1945; Stanghellini, 2009). In other words, this is my own direct experience of my body in the first-person perspective, myself as a spatiotemporal embodied agent in the world (Husserl, 1912-1915a, b; Merleau-Ponty, 1945; Dillon, 1997; Stanghellini and Rosfort, 2013; Stanghellini, Trisolini, *et al.*, 2014;). The body object is the body thematically perceived or investigated from without, as for example by the natural sciences as anatomy and physiology, in the third-person perspective (Husserl, 1912-1915a; b; Merleau-Ponty, 1945; Stanghellini, Castellini *et al.*, 2012). The physical body refers to the body that can be manipulated, e.g. by surgery. The lived body turns into a physical, objective body whenever we become aware of it in a disturbing way. Whenever one's movement is somehow impeded or disrupted, then the lived body is thrown back on itself, materialized or 'corporealized' (Fuchs, 2005). It becomes an object for oneself. The unmediated and pre-reflexive experience of my body is the implicit background of my day-to-day experiences against which I develop a coherent sense of self as a unified, bounded entity, naturally immersed in a social world of meaningful others.

Persons prone to FEDs often report their difficulties in feeling their own body in the first-person perspective and in having a stable and continuous sense of themselves as embodied agents. What seems to be impaired is the coenaesthetic apprehension of their own body as the more primitive and basic form of self-awareness. They have difficulties perceiving – with different extents of insight – their emotions and they do not feel themselves.

This is a typical narrative about the feeling of *elusiveness* related to one's body. The patients is asked to write a letter to her body and here is what she writes:

> *If you were a geometric shape, you'd be a sphere... Elusive... rolling away! I'm not taking you. You don't get caught... Escape! So I feel elusive.*

3. Lived Body-For-Others

In addition to the two dimensions of corporeality (body-subject and body-object) discussed above, Sartre (1943) emphasized that one can apprehend one's own body also from another vantage point, i.e. as one's own body when it is looked at by another person. When I become aware that I, or better my own body, is looked at by another person, I realize that my body can be an object for that person. Sartre calls this the 'lived body-for-others'.

It is necessary to make a premise: to live one's own body as an entity seen by another person is to be considered both a primary data, and a compensatory way of experiencing one's own body.

Each of us experiences one's own body in the first and third person, and we establish our own identity through an integration between these two perspectives.

In people affected by FEDs, this integration is missing because the possibility of feeling oneself from the first person perspective is diminished, and becomes possible only when they are looked at another person. The body is principally given as an object to 'be seen'. It is a body exposed and subjected to the other's gaze.

These are typical narratives highlighting how the in people with FED is a body-for-others:

I feel my weight through the gaze of others.

Others can make you feel beautiful and thin, or ugly and fat.

The gaze of other person gives me a sensation of being.

With the appearance of the other's look, writes Sartre, I experience the revelation of my being-as-object. The upshot of this is a feeling of having my being outside, the feeling of being an object (Stanghellini, 2017). Thus, one's identity becomes reified by the other's gaze, and reduced to the external appearance of one's own body. When this way of apprehending one's body crystallizes, (and so becomes the only way to experience one's own body) it may become more and more difficult to have an experience of one's own body from within. The body, so to say, takes the shape that the others' gaze imposes upon it. This, on the one hand makes one feel shame or disgust for one's own body, but on the other hand helps one recover a sense of 'unity' and 'condensation' – as it is the case with people suffering from FEDs (Stanghellini *et al.,* 2012; Stanghellini and Mancini, 2019).
Persons affected by, or vulnerable to, FEDs often report their difficulties in perceiving their emotions and that they do not 'feel' themselves (Sands, 1991; Goodsitt, 1997; Malson, 1999; Piran, 2001). They have difficulties in feeling their own body in the first-person perspective and to have a stable and continuous sense of themselves as embodied agents. This entails a fleeting feel of selfhood and an evanescent sense of identity. Indeed, feeling oneself is a basic requirement for achieving an identity and a stable sense of one's self (Stanghellini *et al.*, 2012). The experience of not feeling one's own body and emotions involves the whole sense of identity. Indeed, we construe our personal identity on the basis of our feelings, that is, of *what we feel we like or dislike*. For persons with FEDs, since they can hardly feel themselves and their feelings are discontinuous over time, identity is no longer a real psychic structure that persists beyond the flow of time and circumstances. They also feel extraneous from her own body and attempt to regain a sense of bodily self through starvation (Stanghellini, 2017). In other words, the basic phenomenon seems to be that these people experience own body first and foremost as an object being looked at by another, rather than coenaesthetically or from a first-person perspective. Since they cannot have an experience of their body from within, they need to apprehend their body from without through the gaze of the Other. What they seem lack is the coenaesthetic apprehension of their own body as the more primitive and basic form of self-awareness. As a consequence of that, the way one feels looked at by other persons is the only possibility to feel oneself and define one's identity.

4. The Other

FED patients define themselves by the gaze of other persons. The way they feel, even the very possibility to feel themselves, depends on the way they feel looked at by others. In the life-world of these persons the other is reduced to his gaze. The other's look only seizes what is visible, that is, appearance. Also, it only seizes what is present here and now. The temporal dimension of the gaze is the present moment. The gaze does not even expand into the nearest future, as it might in the case of someone gazing at someone else while the latter replies with her own gaze. There is not a dialogue of gazes. The other is not a partner with whom one can dialogue.

Why I starve myself?
Because of all the people in my life who die of jealousy when they see the way I look.
(Source: thepronalifestyleforever)

What does the other's gaze express? It can simply express like or dislike, recognition or non-recognition. The other is a gaze and the patient is a body looking for visual recognition. The other is a gaze that may (or may not) like her. Feeling liked or non-liked helps recover a sense of selfhood and identity, at least in the aesthetic dimension as a here-and- now body object of the other's desire. The other is hardly an interlocutor with whom to engage an intersubjective co-creativity relationship. He is the one who confirms my existence, my being-in-the-world. The gaze of the other becomes the unique way through which one can be aware of one's own presence. It is the mirror in which to see oneself and feel oneself.
In this perspective, the life-world of persons with FED reflects the essential features of late modernity (Stanghellini, 2005): the experience of persons who feel they exist only through the eyes of the others. *Only what is visible really exists*. What we can't see doesn't exist. If no one can see what you have done, what you have done does not exist. The feeling of being a Self and having an identity can be so weak that one may feel one becomes real only when one is the topic of a discourse. Someone who is not relating to some other is in a liquid state; when faced with the other one becomes semi-solid, but at the expense of getting the form imposed by the gaze and the discourse of the other. Only being seen or being talked about gives substance to the Self. Being seen and being talked about by others take the place of the self-feeling of oneself.
These are the answers taken from a pro-Ana blog entitled "*I will finally feel skinny when …*", pinpointing that identity in persons with FED is closely related to appearance and to the others' gaze/discourse:

> *[I am myself] When I'm the 'skinny friend'; When people ask me if I've lost weight.*

To FED people the other is a means, the mirror through which one can apprehend oneself. No true dialectic exists between oneself and the other. The Self takes on the shape imposed by the other's gaze, or the shape of that which the Self believes are the other's expectations – or stubbornly tries to resist the shape the other wants to impose upon oneself. The relationship with the other is an instrumental one, aimed at obtaining a view on oneself. This also affects one's relation with one's own body. This parallels a kind of "industrialization of the body" (Rilke, 1910): the body is not the silent background from which one's own sense of selfhood and personal identity develops, but a *task*. There is a total symmetry between controlling and shaping one's body and controlling and shaping one's life. The body is a fetish taking the place of identity: body-building takes the place of the *Bildung* of oneself as a person.

5. Embodiment and identity

In persons with FEDs, the disturbance of the experience of their own body is interconnected with the process of shaping their personal identity. We appraise the value of things in the world through our body as we feel attracted or indifferent to them. This is the way we understand who we are and what we want to be. Difficulties in feeling oneself reflect difficulties in perceiving one's emotions. Indeed, feeling oneself is a basic requirement for achieving an identity and a stable sense of one's Self (Stanghellini, Trisolini *et al.*, 2014).
Bodily experience and the shaping and construction of identity are interconnected. The body shapes identity in the course of social situations. Sensations of attraction/repulsion, desirability/disgust, as well as all emotions as embodied phenomena (Stanghellini and Rosfort, 2013) are the basis to establish *What* I like and *Who* I am.
Research in this area has provided two main constructs pertaining disorders of identity as maintaining factors in FEDs: severe clinical perfectionism, and core low self-esteem (Murphy *et al.*, 2010). Clinical perfectionism is a system for self-evaluation in which self-worth is judged largely on the basis of striving to achieve demanding goals and success at meeting them (Shafran,

Cooper *et al.*, 2002). The patient's perfectionist standards applies to her attempts to control eating, shape and weight, as well as other aspects of her life (e.g. performance at work or sport).
The psychodynamic perspective underscores impairments in overall identity development and the failure to establish multiple and diverse domains of self-definition. In particular, Bruch (1979) suggested that the dissatisfaction and preoccupation with body image that characterises persons with FEDs reflect a maladaptive "search for selfhood and a self-respecting identity" (*ibidem*, p. 255). The basis for the development of the sense of a core subjective self is represented for Stern (2000) by the interaction between mother and infant in sharing affective states and experiences.
The experience of not feeling one's own body and emotions involves the whole sense of identity. If a person can hardly feel herself and her feelings are discontinuous over time, her identity is no longer a real psychic structure that persists beyond the flow of time and circumstances. This person will also feel extraneous from her own body and attempts to regain a sense of bodily self through coping strategies like starvation or quantification.
Therefore, abnormal bodily experiences and attitudes towards one's own corporeality, and related difficulties in the definition of one's own identity, have been proposed as the core features of FED (Stanghellini, Castellini *et al.*, 2012; Stanghellini, Trisolini *et al.*, 2014; Castellini, Stanghellini *et al.*, 2015; Stanghellini, Mancini *et al.*, 2018; Stanghellini and Mancini, 2018). Whereas most people evaluate and define themselves on the basis of the way they feel in various situations and perceive their performance in various domains, patients with FED judge their self-worth largely, or even exclusively, in terms of their shape and weight and their ability to control them.
Here is a typical narrative, expressing the need to resort to one's own body weight as a viable source of definition of the Self:

When I have doubts about who I am, I go to my old friend: the Scale.

According to Nordbø and colleague (2006), persons with anorexia nervosa may explain their behaviour as a tool for achieving a new identity since changing one's body is a tool to become another (see also Skarderud, 2007a; 2007b). They want to change, and changing one's body serves as a concrete and symbolic tool for such ambition. Thus, shaping oneself is a 'concretised metaphor', establishing equivalence between a psychic reality (identity) and a physical one (one's body shape). The shaping of one's own body becomes a substitute for the construction of one's own identity: body building is the replacement for identity *Bildung*. For persons affected by FEDs identity is a task, not a taken for granted datum (Stanghellini, 2017; Stanghellini and Mancini, 2018; 2019). They have the necessity to perpetually construct themselves. This construction is based on the way they feel seen and judged by other persons. In this perspective, they seem to share with the late-modern mind an aesthetic or *pornographic* conceptualization of the Self (Stanghellini, 2005) based on seeing and been seen and on the approval of Others. Another feature FED patients share with late modernity is the obsession with measures and numbers. These persons are constantly engaged in a sort of conceptual and mathematical process for establishing their own identity (Stanghellini and Mancini, *2019*).

Here is a paradigmatic narrative about self-definition through body digitization:

I can't tell exactly what the body is. I'm what the scale says about my body!

To sum up: in persons with FED the internal perception of one's embodied self (i.e. coenaesthesia) is troubled and, as a compensation to it, these persons experience their own

body as an object that is looked at by others. To FED persons, their body is principally given to them as an object 'to be seen'. The other's look serves as an optical prosthesis to cope with hypo- and dis-coenaesthesia. Identity impairments are related to the alienation from one's own body and the difficulties to experience one's own emotions as stable and reliable ways to establish a representation of oneself. Feeling extraneous from oneself is the core phenomenon in people with FEDs, from which several typical although secondary features derive, namely the need to feel oneself only through the gaze of the others (being a body-for-others), through objective measures and through self-starvation (Stanghellini, Castellini *et al.*, 2012).
All this is nicely encapsulated in the following narrative:

> *"My body" has always existed only on the scale, when I fast, in front of the mirror or in front of others.*

REFERENCES

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).* Arlington, VA: American Psychiatric Association;
Bruch H. (1979). Developmental deviations in anorexia nervosa. *Israel Annals of Psychiatry & Related Disciplines*, 17, pp. 255–261;
Carter J. C., Blackmore E., Sutandar-Pinnock K., Woodside D. B. (2004). Relapse in anorexia nervosa: a survival analysis. *Psychological medicine, 34(04),* pp. 671-679;
Castellini G., Sauro C. L., Mannucci E., Ravaldi C., Rotella C. M., Faravelli C. and Ricca V. (2011). Diagnostic crossover and outcome predictors in eating disorders according to DSM-IV and DSM-V proposed criteria: a 6-year follow-up study. *Psychosomatic Medicine*, *73*(3), pp. 270-279;
Castellini G, Stanghellini G, Godini L, Lucchese, M., Trisolini, F., Ricca, V. (2015). Abnormal bodily experiences mediate the relationship between impulsivity and binge eating in overweight subjects seeking for bariatric surgery. *Psychotherapy and psychosomatics, 84(2),* pp. 124-126;
Dalle Grave R. (2011). Eating disorders: progress and challenges. *European Journal of Internal Medicine, 22(2),* pp. 153-160;
Dillon M. C. (1997). *Merleau-Ponty's Ontology*. Evanston, IL: Northwestern University Press;
Eddy K. T., Dorer D. J., Franko D. L., Tahilani K., Thompson-Brenner H., and Herzog D. B. (2008). Diagnostic crossover in anorexia nervosa and bulimia nervosa: implications for DSM-V. *American Journal of Psychiatry,* p. 165, pp. 245–250;
Fairburn C. G., Harrison P. J. (2003). Eating Disorders. *The Lancet*, *361*(9355), pp. 407-416;
Fairburn C. G., Cooper Z. (2007). Thinking afresh about the classification of eating disorders. *International Journal of Eating Disorders,* 40, S107–S110;
Fairburn C. G., Cooper Z. and Shafran R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment. *Behaviour Research and Therapy,* 4, pp. 509-528;
Fuchs T. (2005). Corporealized and disembodied minds: A phenomenological view of the body in melancholia and schizophrenia. *Philosophy, Psychiatry, & Psychology, 12*(2), pp. 95-107;
Goodsitt A. (1997). Eating disorders: a self-psychological perspective. In Garner D., Garfinkel P. (eds) *Handbook of treatment for eating disorders.* New York: Guilford Press, pp. 205-228;
Husserl E. (1912-1915a). *Idee per una fenomenologia pura e una filosofia fenomenologica* – Vol. 1. Torino: Einaudi Editore, 2002;
Husserl E. (1912-1915b). *Idee per una fenomenologia pura e una filosofia fenomenologica* – Vol. 2. Torino: Einaudi Editore, 2002;

Loeb K. L., Walsh B. T., Lock J., Le Grange D., Jones J., Marcus S. U. E., *et al.* (2007). Open trial of family-based treatment for full and partial anorexia nervosa in adolescence: Evidence of successful dissemination. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(7), pp. 792-800;
Malson H. (1999). Women under erasure: Anorexic bodies in postmodern context. *Journal of community and applied social psychology*, *9*(2), pp. 137-153;
Merleau-Ponty M. (1945). *Fenomenologia della percezione*. Milano: Bompiani Editore, 2003;
Milos G., Spindler, A., Schnyder, U., and Fairburn, C. G. (2005). Instability of eating disorder diagnoses: prospective study. *British Journal of Psychiatry* 187: pp. 573-578;
Murphy R., Straebler, S., Cooper, Z., and Fairburn, C. G. (2010). Cognitive behavioral therapy for eating disorders. *Psychiatric Clinics of North America*, *33*(3), pp. 611-627;
Nordbø R. H., Espeset, E., Gulliksen, K. S., Skårderud, F., and Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders*, *39*(7), pp. 556-564;
Piran N. (2001). V. Reinhabiting the body. *Feminism & Psychology*, *11*(2), pp. 172-176;
Ricca V., Castellini G., Lo Sauro C., Mannucci E., Ravaldi C., Rotella F. and Faravelli C. (2010). Cognitive-behavioral therapy for threshold and subthreshold anorexia nervosa: a three-year follow-up study. *Psychotherapy and psychosomatics*, *79*(4), pp. 238-248;
Rilke R. M. (1910). *I quaderni di Malte Laurids Brigge*. Garzanti Classici, 2013;
Sands S. (1991). Bulimia, dissociation, and empathy: A self-psychological view. In *Earlier versions of the chapter were presented at the 12th Annual Conference on the Psychology of the Self, San Francisco, CA, Oct 12-15, 1989, and at the Division 39 (Psychoanalysis) American Psychological Association meeting, New York, NY, Apr 5-8, 1990*. Guilford Press;
Sartre J. P. (1943). *Being and Nothingness*. New York: Washington Square Press, 1992;
Sass L. (2004). Affectivity in schizophrenia a phenomenological view. *Journal of consciousness studies*, *11*(10-11), pp. 127-147;
Schulte W. (1961). Nichttraurigseinkönnen im Kern melancholischen Erlebens. *Nervenarzt*, 32, pp. 314-320;
Shafran R., Cooper, Z., Fairburn, C. G. (2002). Clinical perfectionism: A cognitive–behavioural analysis. *Behaviour research and therapy*, *40*(7), pp. 773-791;
Skårderud F. (2007a). Eating one's words, Part I:'concretised metaphors' and reflective function in anorexia nervosa - An interview study. *European Eating Disorders Review*, *15*(3), pp. 163-174;
Skårderud F. (2007b). Eating one's words, part II: The embodied mind and reflective function in anorexia nervosa - theory. *European Eating Disorders Review*, *15*(4), pp. 243-252;
Stanghellini G, Rosfort R. (2013). *Emotions and personhood. Exploring fragility. Making sense of vulnerability*. Oxford: Oxford University Press;
Stanghellini G, Trisolini F, Castellini G, Ambrosini A, Faravelli C, Ricca V (2014). Is feeling extraneous from one's own body a core vulnerability feature in eating disorders? *Psychopathology*, 48: pp. 18-24;
Stanghellini G., Mancini M. (2018). *Mondi psicopatologici - Teoria e pratica dell'intervista psicoterapeutica*. Edra-Masson Editore;
Stanghellini G., Mancini M. (2019). Abnormal time experiences in persons with feeding and eating disorder: a naturalistic explorative study. *Phenomenology and the Cognitive Sciences*, Springer;
Stanghellini G. (2005). For an anthropology of eating disorders. A pornographic vision of the self. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 10(2), pp. 21-27;
Stanghellini G. (2009). Embodiment and schizophrenia. *World Psychiatry 8*, pp. 56-59;
Stanghellini G. (2017). *Noi siamo un dialogo. Antropologia, psicopatologia e cura*. Milano: Raffaello Cortina Editore;

Stanghellini G., Castellini G., Brogna P., Faravelli C. and Ricca V. (2012). Identity and eating disorders (IDEA): a questionnaire evaluating identity and embodiment in eating disorder patients. *Psychopathology,* 45, pp. 147-158;
Stanghellini G., Mancini, M. (2017). *The therapeutic interview. Emotions, Values, and the Life-World.* Cambridge: Cambridge University Press;
Stanghellini G., Mancini M., Castellini G., Ricca V. (2018). Eating Disorders as Disorders of Embodiment and Identity: Theoretical and Empirical Perspectives. In *Embodiment and Eating Disorders*, McBride, H. L. & Kwee J. L. (eds) pp. 139-154. Routledge;
Stern D. N. (2000). *The interpersonal world of the infant*. New York: Basic Books;
Tozzi F., Thornton L. M., Klump K. L., Fichter M. M., Halmi K. A., Kaplan A. S. and Rotondo A. (2005). Symptom fluctuation in eating disorders: correlates of diagnostic crossover. *American Journal of Psychiatry*, 162(4), pp. 732-740.
Williamson D. A., White M. A., York-Crowe E., Stewart T. M. (2004). Cognitive-behavioral theories of eating disorders. *Behavior Modification*, 28(6), pp. 711-738.