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A Model of Integrative Psychotherapy H.E.A.L. A Case Study

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Abstract

Background: The eating disorder disease known as bulimia nervosa (BN) typically appears between adolescence and early adulthood, with a median onset age of 12. In order to manage weight gain, people with BN often engage in odd compensatory behaviors after episodes of excessive food consumption. Roughly 94% of people with BN either put off or never seek therapy. Even though there are therapies available, certain communities lack access to them. If BN is not treated, it may worsen and result in additional dangerous comorbidities. Our proposed therapeutic model with the theoretical formulations of an enriched therapeutic perspective named H.E.A.L will be presented. Individuals, couples, and groups are all included, and it incorporates a range of cognitive-behavioral, systemic, attachment theory-based elements and neuropsychotheraputic techniques. The theoretical perspective of the model incorporates findings of neuroscience and neuropsychotherapy, psychodynamic and humanistic approaches (attachment theory, person-centered theory), cognitive therapies, narrative exposure theory and somatic experiencing modalities. H.E.A.L. describes an extended version of the stages of this intergrative model. **Case Presentation**: This case study will focus on A, a female aged 23 with Bulimia Nervosa, (moderate severity), and average of 4 - 5 episodes of inappropriate conpensatoty behaviors according to DSM-5. The patient was recommended after a psychiatric evaluation with issues except from psychogenic bulimia, such as anxiety attacks, depressive symptomatology and low levels of functioning. She completed three pre- and post-intervention questionnaires, the Beck Depression Inventory (BDI) Beck Anxiety Inventory (BAI) and GAF Scale. Also the Eating Disorder Examination Questionnaire (EDE-Q) at the beginning of the intervention and at the end, the Eating Disorder Recovery Questionnaire (Dr Greta Noordenbos, Psychological Institute of Leiden University) After the intervention she showed reduction in Depression Inventory Scores, BAI scores and on the GAF scores. She also reduced bulimic episodes to one per month and she demonstrated changes

overall in eating behavior, body image, self-confidence, emotional regulation, and social relationships and partnerships. **Conclusions**: The patient showed changes in three mental health indicators of depression, anxiety and overall well-being. She also demonstrated a change in the frequency of bulimic episodes, a balanced relationship with nutrition, and overall satisfaction with life.

Keywords

H.E.A.L., Intergrative Model, Bulimia Nervosa, Case Study

1. Introduction

A severe eating disorder (ED), bulimia nervosa (BN) typically appears in adolescence or early adulthood (Hail and Le Grange, 2018). Recurrent episodes of binge eating are a hallmark of BN (Martins et al., 2020). Self-induced vomiting, abusing laxatives, diuretics, or enemas are examples of compensatory behaviors that are part of BN (Mond, 2013; American Psychiatric Association, 2022). Fasting and extreme exercise are examples of further compensatory behaviors (Mond, 2013; American Psychiatric Association, 2022). In any 2-hour period that is longer than most people would experience in a comparable period, the episodes, which might be mixed, are categorized as repeated episodes of binge eating (Mond, 2013; American Psychiatric Association, 2022).

Binge-eating episodes may be anticipated and strategically scheduled, reflecting the pervasive cognitive and behavioral disruptions associated with the disorder (Harrington et al., 2015). Epidemiological data indicate a median age of onset at approximately 12.4 years, with cases spanning a broader age range of 18 to 44 years. Lifetime prevalence rates are estimated at 0.5% for males and 1.5% for females (Hail & Le Grange, 2018; Udo & Grilo, 2018).

Despite the severity of the disorder, a significant proportion of individuals—ranging from 85% to 94%—either delay seeking professional intervention or remain untreated for extended periods, often spanning four to five years (Mathisen et al., 2017). Untreated BN is associated with a range of deleterious outcomes, including the exacerbation of psychiatric comorbidities and elevated risk of mortality. Psychological correlates such as depression, anxiety, shame, impulsivity, and hopelessness are prevalent and may contribute to suicidal ideation, suicide attempts, and non-suicidal self-injury (Nitsch et al., 2021).

Psychotherapeutic intervention is widely recognized as the primary treatment modality for BN. While existing therapeutic approaches have demonstrated clinical utility, their overall efficacy remains limited in addressing the disorder's multifactorial etiology and chronic nature. This reality underscores the imperative for continued refinement of current models and the development of novel, integrative psychotherapeutic frameworks capable of addressing the complex psychological, behavioral, and relational dimensions of bulimia nervosa.

1.1. Foundations of the Model

Our proposed model is based on Nicki's Dummett work (Dummett, 2004; 2006; 2010) on Systemic CBT formulation. The particular formulation is based on the Beckian cognitive model (Beck et al., 1979), the Five Areas model (Williams, 2001), and the four functionally distinct components of response (affective, cognitive, physiological, and behavioral) (Rachman, 1978). These domains encompass individuals' life circumstances, interpersonal relationships, and practical challenges, as well as disruptions in cognitive processes, emotional states, somatic experiences or physical symptoms, and behavioral or activity patterns.

1.2. The Role of the Therapist and the Importance of the Therapeutic Relationship

This model integrates core principles of Bowlby's attachment theory, particularly those pertaining to the therapeutic relationship, which is regarded as a fundamental component and primary mechanism through which psychological change occurs. As articulated by Levy (2013, p. 1133), Bowlby (1988) identified four essential components that constitute the foundation of effective psychotherapy.

First, the establishment of a secure base enables clients to develop an internalized sense of trust, care, and support, thereby creating the psychological safety necessary for the exploration of their internal world, including aspects that may be distressing or difficult to confront. Second, the therapeutic process involves the exploration of early attachment experiences, which assists clients in processing and reflecting on both past and present relational patterns, particularly in terms of emotions, expectations, and behavioral tendencies.

Third, emphasis is placed on the therapeutic relationship itself as a microcosm for relational functioning, offering clients a reparative context through which they can gain insight into how they relate to others and begin to cultivate healthier interpersonal experiences both within and beyond therapy. Fourth, the revision of internal working models is a critical objective; clients are encouraged to examine their current emotional and cognitive responses and to adopt new, more adaptive ways of thinking, feeling, and behaving that differ markedly from patterns rooted in earlier attachment experiences.

In addition, Levy et al. (2018) propose a fifth essential component: the creation of a symbolic safe space within therapy—an internalized sanctuary that clients can mentally access during times of emotional distress, offering ongoing psychological support even outside the therapeutic setting.

1.3. The Importance of Group Therapy

Group psychotherapy offers several distinct therapeutic advantages, making it a valuable modality in clinical practice. One key benefit is the recognition of shared human experiences, which fosters a sense of universality—the understanding that one is not alone in their struggles. As noted by Yalom & Leszcz (2020), this principle helps normalize individual difficulties and reduces feelings of isolation.

Group settings also provide opportunities for both giving and receiving support, which are essential elements in the therapeutic process. The act of offering support to others facilitates personal growth, empathy, and insight, while receiving support enhances feelings of connection and contributes to the development of a therapeutic alliance within the group context.

Moreover, group therapy promotes the development of communication and interpersonal skills. Participants learn to articulate their concerns, engage in active listening, and respond to constructive feedback, all of which contribute to improved social functioning. The diversity of perspectives within a group further enriches the therapeutic experience, allowing for the integration of multiple viewpoints and enhancing cognitive and emotional flexibility.

Self-awareness is another core benefit, often emerging as individuals reflect on the experiences and challenges shared by others. Discussing one's difficulties in a supportive and structured environment can be deeply therapeutic, as it allows for emotional processing, validation, and mutual understanding.

Furthermore, the group serves as a psychological safety net for individuals who may initially be hesitant to disclose vulnerable emotions. The supportive environment encourages risk-taking and emotional openness. Lastly, group therapy facilitates observational learning through modeling, whereby individuals adopt adaptive behaviors and coping strategies by observing peers who have successfully navigated similar challenges.

Group psychotherapy has been shown to be equally effective as individual therapy for a range of psychological conditions, including schizophrenia, eating disorders, depression, anxiety, and bereavement (Burlingame & Strauss, 2021). Given the intersectional mental health effects of COVID-19, racial injustice, and healthcare inequality—all of which have exacerbated emotions of loneliness, loss, despair, death salience, and uncertainty—this is particularly crucial (Marmarosh & Sproul, 2021).

Recent studies have concentrated more exclusively on the treatment of certain diseases, despite the literature's demonstration of group therapy's unique benefits in promoting belonging, universality, optimism, compassion, and meaning (Yalom & Leszcz, 2020).

Empirical studies on groups are becoming more focused on efficiently resolving symptom discomfort, which is indicative of psychotherapy research in general. Although it is undoubtedly a key component of high-quality care, this method can reduce patients to their symptoms and ignores important aspects of the human experience. In contrast, Williams (2001) contended that it is crucial to consider holistic developmental and well-being outcomes, which are characterized as "vital signs" in psychotherapy and include the ability to forgive, be grateful, hope, tolerate differences, and empathize, in addition to symptom change. In keeping with the fundamental values outlined by Seligman (1998; 2019), these concepts are included in the field of positive psychology.

Group settings create a powerful dynamic for healing. Groups offer a micro-

cosm of the external world within a safe, therapeutic context, allowing individuals to explore their internal systems while interacting with others. This setting provides a unique opportunity for participants to witness and engage in the healing processes of others, promoting empathy, connection, and mutual support.

Building Safety and Trust

Group therapy is establishing safety and trust among group members. This involves setting clear guidelines and boundaries, ensuring confidentiality, and creating an atmosphere of non-judgment and acceptance. The therapist's role is to model Self-energy by demonstrating qualities such as curiosity, calmness, and compassion, which encourages similar responses from group members.

Exploring Individual and Collective Parts

In group therapy, participants are guided to explore their parts and share their experiences with the group, if they choose. This sharing helps demystify personal struggles, as members realize the commonality of their experiences and the universality of having parts. Through guided exercises, members can work on identifying, acknowledging, and interacting with their parts in the presence of the group, fostering a sense of shared humanity and collective healing.

1.4. Description of the Model

The proposed model refers to individuals, couples and groups. Biological, psychological, and sociocultural systems are all impacted by dysfunction. As a precondition for therapeutic change, the paradigm emphasizes the individual and the growth of the therapeutic alliance. encompasses a range of person-centered, systemic, behavioral, narrative, and cognitive strategies (Androutsopoulou, 2001; Katakis, 2002). Depending on each case's aims and stage of treatment, the therapeutic approach may be more explanatory or less structured, but it also incorporates psycho-educational strategies (e.g. training in assertive behavior). While focusing on the present, it also emphasizes on the ways that the individual has been interacting with family and authority figures at various ages and stages in life.

1.5. Stages of therapy

H. E. A. L.

1) Halt: Pause to consider myself and/with the problem.

This first stage includes: Familiarization with the model of psychotherapy and the therapist, therapeutic contract, clinical interview, begin a therapeutic relationship, psycho-education in relation to the problem-request, treatment goals, self-observation between sessions and journaling.

This stage of therapy aims to identify patterns of thought, cognitive distortions, emotions, behaviors, which links to the problem. Narratives about oneself, others, the world and the dominant issues that concern the patient are evaluated. Psychoeducation in disorder is also necessary to introduce the client to the disorder's function and impact on health, relationships, functioning, etc. depending on the request. Psychoeducation can, however, concern the functioning of the relation-

ship and what serves the members if it concerns couples therapy. The aim in this first phase, for the patient is to recognize on a mental level the function of the problem and on a second level if necessary what sort of attachment pattern appear to be mostly familiar with, deriving from her family of origin? How does this pattern affect her adult relationships, recognize the vicious circle of the problem that concerns him and gain a sense of control around his symptoms. In many cases treatment ends here. (up to 12 sessions)

2) Engage: Connection with old self, family patterns and aspects of trauma.

The second stage aims to make a connection with old self, family patterns and aspects of trauma. (the attachment type and the impact on emotional regulation) Acquaintance with the inner child and roles in the family. It is the client's first attempt to intergrate within his/her personal history past with present, bodily symptoms, family patterns and recognize emotions as anger about several important issues. Experiencing emotions and narrating the unspeakable brings new behaviors to the surface, the therapeutic relationship takes center stage again and is the safe framework that will withstand the unpleasant. The stage enters the usage of psychotherapeutic techniques as assertiveness training, the exploration of the therapeutic use of dreams and others in order to help the client to claim and experience boundaries and alternate emotional abuse to personal limits. Through this procedure client reconstruct also family boundaries ("fly" from family). It can also be a state from problem talk to solution talk, behavioral experiments, exposure to phobic stimuli. Somewhere in the middle (or even the beginning) of this stage this transition from individual to group is favored where it will function enriching on many levels.

3) Allow: Creating the meaning of life.

The third stage leads to more deep self exploration, and self exposure. Specifically aims to confront trauma and experience anger and grief for past losses. Also attempts reconciliation with personal life story. The client gives meaning to personal experiences and recognizes problems as a personal journey of self-abuse. Throughout the stage cognitive restructuring takes place.

4) Live: Authentic self.

In the last stage individuals learn how to exist under new conditions and to synchronize all aspects of old and new in order to synthesize the new Self. As the therapy ends client makes subconscious therapeutic connections to reconstruct personal and family patterns. It is also called as "Ghost" phase (therapist is there without being there). The internal "supportive voice" of the therapist continues to create constructive internal dialogues helping to manage with difficult situations now and in the future. The goal of the HEAL model is to reunite the self, which in the course of life can be divided through disruptive experiences, (authentic self)

Stages 1, 2, 3 make cycles, close and start over whenever a client need to enriches further more.

2. Case Study

This case study will focus on A, a female aged 23 with Bulimia Nervosa, (moderate

severity), and average of 4 - 5 episodes of inappropriate conpensatoty behaviors according to DSM-5. She developed her eating disorder due to her fear of growing up. Her family had issues with food which was a distorted way of communication Her mother has a history of binge eating disorder and her father has the same and also suffers from obesity, with many failed weight loss attempts in his history. She is a young woman with quite functional behavior in everyday life, she works in a company, she has stable friendships and social life but she has a hard time in romantic relationships with many, short-term and unstable bonds. She also chooses partners who repeatedly abuse her emotionally. The referring psychiatrist informed us about disordered eating behaviors and mood and anxiety disorder. The client additionally displayed severe and deeply ingrained eating disorder cognitions, including shame when she looked in the mirror, panic at the idea of consuming calories, and obsession with food and strict eating regulations to control weight. in reaction to her weight and food anxieties. As a result, she developed compensatory behaviors like periods of restrictive eating and induced vomiting following bulimic episodes. She claimed to be quite depressed. Her depression was characterized by themes of sadness, disinterest, slowness, self-dislike, and viewing oneself as a failure who causes trouble for others. She had no desire to question her eating condition and anxiety-based beliefs. She scored 42 on the Beck Depression Inventory (BDI) and 26 on the Beck Anxiety Inventory (BAI). And 10 on the GAF Scale at the beginning of the intervention. She demonstrated the highest high score on the EDE-Q on 3 of the 4 subscales namely Eating Concern Subscale Shape Concern Subscale Weight Concern Subscale. EDE-Q On a scale of 0 to 6, participants submit their responses; higher scores reflect more frequent and/or severe episodes of ED psychopathology during the preceding 28 days. Several clinical and non-clinical samples have been used to validate the EDE-Q.

The Beck Depression Inventory Aaron T. Beck developed the Beck Depression Inventory (BDI), one of the most used self-report assessment instruments for gauging the intensity of depression symptoms. Higher scores indicate correspondingly greater severity of depression symptoms. The questionnaire's total score can vary from 0 to 63. Assessing the intensity of anxiety symptoms and providing an objective gauge of anxiety levels are the main goals of the Beck Anxiety Inventory (BAI) (Beck et al., 1988). It is intended to distinguish anxiety from depression by emphasizing the cognitive and bodily signs of anxiety, such as tension, fear, or worry. An evaluation of an individual's anxiety level can be obtained by interpreting the total score: 0 - 7: Minimal anxiety; 8 - 15: Mild anxiety; 16 - 25: Moderate anxiety; 26 - 63: Severe anxiety.

Higher scores correspond to higher anxiety levels, and the classification aids researchers and mental health providers in understanding the severity of symptoms and directing the choice of intervention tactics. GAF stands for the Global Assessment of Functioning Scale. An individual's total level of psychological, social, and occupational functioning is measured using the Global Assessment of Functioning (GAF), a scale with a range of 1 to 100 (Aas, 2011). In order to give

doctors a single, succinct score that represents a patient's functioning and symptom intensity, it was included to the DSM-IV-TR (Stein et al., 2010). However, because of issues with subjectivity and scoring variability, it was not included in the DSM-5 (Gspandl et al., 2018). Functioning is broken down into ten items on the GAF scale. While scores between 1 and 10 indicate serious impairment, such as the inability to maintain basic hygiene or a chronic risk of damage to oneself or others, scores between 91 and 100 show exceptional functioning with no discernible symptoms. Three broad domains are evaluated by the scale: social functioning (such as the capacity to sustain relationships), psychological functioning (such as signs of anxiety or depression), and vocational functioning.

Progress of Therapy

The client came with a request not only for the eating disorder but also because she wanted to understand what was happening with her choices to romantic partners. At the end of the 1 year individual therapy, she had gradually improved her eating habits, become more receptive to new experiences, and reduced her negative and pervasive thought patterns. Family members define their responsibilities and make a clear distinction between fighting their daughter's disease and fighting against her. She then participated in group psychotherapy where she gradually completes after 2 years and graduated.

Halt: In the first stage, the therapeutic alliance began in a very warm climate, also the diet recordings took place systematically, psychoeducation for the disorder, the vicious circle of bulimia (periods of intermittent fasting followed by bulimic episodes), began at the urging of the therapist collaboration with a specialized dietitian in eating disorders, reduced episodes from four per week to one and the first stage is successfully completed and now clearly recognizes the function of the disorder in her life.

Engage: In the second stage she comes into contact with the family patterns of communication, the inner child and the role she had in the family. As bulimic episodes decrease, dysphoric feelings emerge in relation to self, relationships and life in general, Experiencing unpleasant feelings in the context of therapy is particularly important. The focus is now on the relationship with the mother, the acquaintance with the internalized working model (ambivalent type of emotional attachment) and the relationship with food. The number of bulimic episodes remains stable at one per week, but the focus is on the relationship with others. Behavioral experiments such as training in assertiveness, contact with emotions and their disconnection from bulimia. She also starts group psychotherapy.

Allow: In the third stage, the client creates stable relationships with the group and the therapists as restorative figures. The group functions as a symbolic family, the client in her effort to experiment with new behaviors in relation to food and at the same time to manage unpleasant emotions in a group that supports her and reflects care and framing. It allows for change in dysfunctional beliefs that come to the surface, are replaced and negotiated, with new, more functional, more fo-

cused on give and take as a piece of self-correcting restorative experiences.

Live: The client will merge old and new sides, a new self emerges, her perspective is not in the past but in the present and to a functional future, There are new ways to relate with food, with the self and the others. Bulimic episodes take place once a month so as not to stop the journey to new self and a conscious lifestyle appears in general where listening to her needs is part of everyday life. Treatment continues (Table 1).

Table 1. Examples of specific processes during HEAL psychotherapy.

GOALS	TECHNIQUES
1) Contact with present moment, mindful eating	Neuropsychotherapy, mindfulness, breathing techniques
2) Expressed depressive and fearful emotions without making an effort to suppress them (typically by trying to manage or bargain with such emotions)	training in assertiveness,
3) Contact with emotions and their disconnection from bulimia.	group psychotherapy.

3. Conclusions and Discussion

Integrative model HEAL is effective in treating clinical situations as eating disorders. It is a structured intervention that adheres to a broad framework that is adjusted for every unique situation. It is very important that the HEAL therapist follows his/her client needs. "It is essential that the therapist provide a clear rationale for each session at the outset and collaboratively structure the session agenda, progressively fostering the client's autonomy and capacity to independently determine the focus of sessions as the therapeutic process advances. The good rapport established with the client will add greatly to his/her compliance with treatment. Apart from that the role of group therapy is essential for the progress of the therapy. Further evaluation of this approach is necessary.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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