

WHAT IS THE PSYCHOLINGUISTIC MOTIVATIONAL MODEL?

Psycholinguistic: brings together the theoretical and practical tools of psychology and linguistics to study the mental processes underlying the use of language. It refers to how a person receives, processes, and transmits experiences through language.

Psycho - from Greek *psyche* - *life of soul*

Linguistic - from Latin *lingua* - *language*

Motivational: is an intentional mental strategy which recognises and gives a person motive or incentive to do something, solve a problem, search for a way to change, etc. It needs to be understood as something one does rather than something one has.

Model

A way of studying the patterns of language, feelings, and behaviour that are used to attain a specific result.

Methodology

A particular process rather than content oriented approaching intra- and interpersonal communication. Comes from Greek *methodos* - *pursuit of knowledge*.

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Collection of Techniques

A range of procedures for making changes in recovery from eating distress

UNDERSTANDING EATING DISTRESS

We have been hearing a lot about Eating Disorders in the media over the years, but very little about Eating Distress. What is the difference?

Eating Disorders such as Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder and Eating Disorders Not Otherwise Specified are labels listed in psychiatric manuals defining a person's behaviour. Different types very often overlap and even the top experts agree that it is difficult to make a clear diagnosis. But all of these labels are only the symptoms of the condition known as Eating Distress (ED).

Eating Distress is a condition where the mind culminates all of the negative assumptions the person has about him or herself. The negative mind becomes more powerful than the positive mind and has much more influence on the person's thinking, feeling and behaviour. This state of mind develops subconsciously and the person is not always aware that they are victims of this negative condition.

Often we read that sufferers have low self-esteem. However, in reality, he or she has no sense of self at all. Therefore, this condition is extremely abusive and manifests

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

itself with highly self-destructive symptoms in which an eating disorder is one. They are all different manifestations of one basic condition.

People suffering from Eating Distress have difficulty with the simple act of eating when hungry, and stopping when they are full. The condition takes over the control of their food intake. Often it can be recognisable by an unhealthy obsession with food and body, which comes to occupy centre stage in the sufferer's life. Food becomes the most important relationship - but it is never a happy one or an easy one. Slowly and surely everything is eventually excluded while thoughts constantly centre on food or the body.

Eating Distress is not a problem; it is a solution to other underlining issues. It is also a way of communicating with inner unhappiness. Controlling the body is a way of controlling life. Control is the centre of the sufferer's life. ED is very preoccupying. That is the function of the disease. It occupies the mind fully and excludes other issues. It is a cushion against painful reality. ED is a symptom of how the person relates to the world. Obsessive thinking about food is only a lonely substitute. ED is a very private disease and is usually not brought voluntarily to the attention of health professionals.

Remember, anyone can suffer from ED at any age.

ANOREXIA AND OVEREATING: *TWO SIDES OF ONE COIN*

Although the signs and symptoms appear dramatically different among all forms of Eating Distress, there are a great number of common causes and similarities especially when it comes to emotional factors and influences. The most common element surrounding ED is the inherent presence of an extremely low self esteem.

Having ED is much more than just being on a diet. ED permeates all aspects of every sufferer's life as well as their loved ones. Both extreme forms of this condition are an attempt to make someone's life better through eating or not eating. This is done with or without the awareness that it is not just the behaviour but, the attitude to life that needs to change.

Men and women living with any form of ED suffer a combination of very similar symptoms. They use their behaviour as a way to hide from their emotions; to fill a void they feel inside; and to cope with daily stresses and problems in their lives. All ED behaviours whether bingeing, starving, over-exercising or another destructive behaviour, can be used as a way to keep people away. Often these behaviours are used as self-punishment for doing 'bad' things, or for feeling badly about themselves.

Focusing on diagnosing ED can be dangerous. Diagnosing doesn't help the sufferers; it only helps the professionals to communicate better about the condition. When people with ED read diagnostic criteria, they usually think, "I don't have all these symptoms, so I must not suffer from anything, I do not really have it. That means I am okay."

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Both Anorexia and Emotional Overeating sufferers seek and desire acceptance, affection and approval from everyone. The only way they know how to achieve this is with the ED behaviour and thinking. Denial of the damage that the behaviour is causing is necessary to achieve that. Trying to find a way of coping, combined with the constant need for love and validation, and the inability to see love even when it is there, turns the person to obsessive episodes of destructive behaviours as a way to numb the pain.

Sufferers of all forms are convinced that the whole of life hinges on what size and weight they are and how they look. The underlying logic behind this is not selfish. The focus on size and shape is an attempt to control life through weight. People experiencing ED are sometimes aware that there are some abnormalities in their thinking, but shame and society's lack of understanding push them back into denial.

Being overweight in our society means being unaccepted and lazy; someone who doesn't have will power or self discipline; and a weak individual. We still have a "pull yourself together" attitude. People are often told to 'just go on a diet'. This suggestion is emotionally devastating to a person suffering from Emotional Overeating in exactly the same way as 'just eat' impacts a person suffering from Anorexia.

Some similarities between different forms of Eating Distress:

- Anxiety associated with fear of weight gain
- Lack of self-acceptance that drives the person to look for external ways of changing themselves so that they can become acceptable in our society
- Feeling that happiness is inevitably linked with a person's weight
- Weight loss or refraining from eating is viewed as a major accomplishment
- Black and white thinking
- Minimising important matters and maximising less important matters
- Wasting a lot of time analysing and ruminating instead of taking action
- Using destructive behaviours to numb feelings and to cope with unexpected life events
- Disconnection between the body and mind; not able to listen to the body's requirements
- Coping with feelings and emotions like loneliness, shame and guilt by dysfunctional eating
- Very sensitive to other people and to the environment
- Suffering from '*tomorrow syndrome*' and '*if they only knew*'
- Difficulty connecting with the outside world
- Feeling out of control but having a strong need to control their body shape, size, and eating patterns
- Not realising that the ED controls the person
- Constant fear of the unknown and change; worries become a major preoccupation
- An inability to enjoy receiving and feeling deserving of the good things in life
- Experiencing a lot of anger which is not expressed or addressed appropriately but is instead diverted toward destructive behaviour
- Feelings of insecurity and helplessness when dealing with the world around them

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

- Sensing that controlling weight will reduce negative feelings
- Valuing perfectionism and believing that anything less than excellent means failure
- A morbid fear of failure
- Lack of meaning in the world

EMOTIONS, FEELINGS AND HEALTH

Our physical bodies are constantly expressing what our mind is talking about. You do not achieve good health overnight - you have to work on it. You get out of it as much you put in to it. The body is the shadow of the soul. (Marsilio Ficino)

Psychoneuroimmunology - mind and body medicine that examines the relationship between the mind, the emotions, and the body. It is based on the premise that mental and emotional processes (the mind) can affect physiological function (the body). Our psychological, behaviour, and physical processes are closely integrated. Illnesses don't just happen to us.

Many researchers believe that the inability to express emotions is an even greater cause of disease.

'Emotions have to be expressed somewhere, somehow. If they're repeatedly suppressed, and there is a conflict about controlling them, they then often show themselves through physical symptoms.'

Domeena Renshaw, Professor of Psychiatry, Loyola University

'Sometimes, because of complex emotional situations, we may even create illness or turn to it as a solution. Sickness gives people permission to do things they would otherwise be inhibited from doing.' Bernie Siegel, Yale Surgeon

A number of researchers show that emotions have strong influences on a wide variety of conditions - everything from car accidents to skin disease.

Negativity is an emotional, spiritual force, which has a compounding effect on the body. What we focus on becomes our reality. Many people think negative thoughts because they think they have to. They have thought negatively for so long that it has become comfortable for them. One cannot think negative thoughts and achieve positive results. Negative thoughts are destructive. To achieve different result, you need to think differently.

DENIAL

Every ED includes a built-in mechanism for perpetuating itself; a subconscious, selective blindness called *denial*. A person can deny having a problem and/or the harm it can cause to themselves or others. A person may really believe that they have the situation under control. The ED sufferer believes that the solution is to lose couple more pounds.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Most sufferers feel that the situation is 'not so bad' and if it is bad it has nothing to do with their ED. This distortion is a **psychological defence mechanism**. Camouflaging facts or minimising their impact gets them through crises and painful periods as safely and 'normally' as possible.

The Process of Coming out of denial and attempting change:

- The person does not see a problem and does not consider attempting any changes. He/she really is not thinking about the problem as a problem.
- The person is starting to have mixed feelings. He/she is able to see that their behaviour or maybe even their thinking is not natural. They are also aware of the advantages of staying in the condition because of the danger of change.
- The person starts to think about the change.
- The person is realising that change is necessary and unavoidable. The person is getting ready to change.
- The person is actively doing something about their abnormalities in their behaviours and thinking.

Ambivalence, meaning not really seeming to care one way or another, may be present at any stage. The person is unlikely to progress simply through these stages one by one. People often go around and around adding more elements to their change.

If you are willing to help, your concern may be met with different response, such as:

- *'How dare you!'* The person will not welcome your concern and may get furious at you and tell you there is no problem.
- *'Mind your own business!'* The person may tell you it is his/her life and he/she can do what he/she wants.
- *'You are not so great yourself!'* Best defence is good offence and you might find yourself being attacked.
- *'You are wrong!'* You will be told you are panicking and it is you who has the problem.

No one likes to be confronted with a secret, which they are ashamed of. It is important to remember that anger is a normal response. The anger is masking the fear and shame. The person feels something is going to be taken from them.

Recovery begins when a person recognises and acknowledges just what is happening.

FAMILIES, FRIENDS AND AN EATING DISTRESS

The term **'family'** describes a *'unique cluster of people who enjoy a special relationship by reason of love, marriage, procreation, and mutual dependence'*.

Friends and family members are often the forgotten victims of ED. It is often difficult to know what to do for the person or for yourself and other family members. As a family member or friend, the most important point to remember is that no one can control another person's behaviour. We do, however, have power over our own

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

actions. Therefore, the first step to a successful journey to help someone recover from eating distress is to decide to expand one's **knowledge of the condition**. Not understanding can set the family on a dangerous course.

It is important to note that the family's involvement will be different from case to case depending on the sufferer's age and whether or not they reside in the family home. The younger the client, the more the family needs to be involved. Experience and literature indicate that the family's first reaction to the knowledge of ED in their offspring is anxiety and guilt.

Therefore, the first step in the recovery process with the family is to lower the anxiety levels and address the feeling of guilt. Families need to develop trust in the therapeutic process and take a supportive role by learning about the condition.

ED affects each and every member of the family. Some members may develop anxiety concerning the ill member's state of health. Siblings and other members may begin to feel neglected, as the sufferer becomes the focus of attention. The family's communication and other activities can be disrupted in order to accommodate the ill person's needs. The good news is that although this is often a painful and stressful process, the family system as whole will improve if the family or at least some members have the desire to change.

It is important for family members to take appropriate care of themselves and to focus on the positive. These changes enable the family to communicate differently and, therefore, slowly allow the child to express themselves more openly. The sufferers need as well to be given space to express her/his emotions, and learn to develop new strategies to cope with stress and daily hassles using verbal rather than non-verbal, behavioural communication.

As the family's understanding of the condition grows, it is emphasized that the parents and the therapist form a team with the client against the condition. This alliance allows the client to feel fully understood and progressively restores and creates for him/her the feeling of unconditional love.

It is important to express concerns, fears and observations, but in a loving and non-judgemental manner. Even if this is not received very well, it is important not give up! *People who have recovered from this illness often state that being loved as they are, being believed in, and not being given up on were crucial factors in their recovery.*

Many people who try to help sufferers tend to focus immediately on the food issues. However, usually something much deeper than eating is bothering the person. They have channelled their negative emotions into a destructive coping mechanism of which controlling food is only *one symptom*. Most of the time, the sufferer is not fully aware of this process.

If someone in the family develops an ED, it is time to listen. Eating is only a symptom of underlying concerns.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Parenting can often seem overwhelming making parents want to turn to experts for advice and just follow 'good rules of parenting'. But parents have usually more information than they are aware. It is quite common to find that sufferers are often uncertain of the parent's love even if it is constantly repeated.

Neither the patient nor the family can be blamed or criticised for developing an ED.

Parents are confused and shaken by the many conflicting health messages. They need to learn to trust themselves again. Parents need to learn to trust their own judgments again and feel confident in their parenting abilities. **Learn to enjoy parenting.**

Parents and professionals need to work together and speak the same language of positive values and hope. We all need to remember that weight, eating and health cannot become an obsession that makes one's life worthwhile. Wellness and wholeness are not about attaining perfect health or even longevity. Wellness and wholeness should be about improving our present quality of life in emotional, social and spiritual ways.

Cooperation between family and professionals can restore normal eating by creating a supportive atmosphere without fears and anxieties. The family involvement is very beneficial to the recovery of the client. However, the involvement should be properly guided so that the family member plays a supportive role in the treatment process rather than trying to be the therapist. Their negative feelings need to be worked out in family educational sessions with a competent eating distress practitioner. A flexible, low-key approach focusing on supporting the child with unconditional love and acceptance helps to reduce the tensions and fears.

Mothers, fathers and significant others in children's lives who are worried about their own weight and talk about the fat or calorie content of food and voice these concerns, can influence children at very early ages. A parent's anxiety about a child's weight adds to the tension, fear and confusion a child may be feeling. **Families need to be safe places where children are seen as beautiful individuals.** Children need reassurance that every person, not depending on their weight, is okay, just as he or she is. **Parents and Professionals need to model and teach active living, positive outlook on life and as part of that, normal eating.**

If distorted eating patterns arrive it is time to listen. When a child presents with eating difficulties, often parents are surprised by the extent to which their child has been able to hide changes in their feelings and behaviour. A number of eating behaviours can cause concerns: food phases or trends and restrictive eating, selective eating of the pre-school years, overeating during growth spurt, food phobia to name a few.

It is not recommended to attempt to influence these behaviours too vigorously. It is best to just monitor intake changes and discuss them with a professional practitioner who understands eating distress. **Age is no barrier to developing eating distress.** People usually think of childhood as a happy time. They tend to forget that it is also a time of emotional bumps and bruises, many of them painful and upsetting.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

The changes to look for:

- Mood changes
- Development of different rigid routines
- Defiance and stubbornness
- Increase attempts to worry about others
- Self-dislike
- General irritability
- Difficulties in sleeping
- Fear of gaining weight
- Social withdrawal and isolation
- Using a lot of salt, vinegar or spices
- Drinking a lot of water or diet drinks
- Extreme irritability when meal times are changed
- Denying hunger
- Measuring self-worth in terms of amount of food eaten
- Secret eating and storing food or hiding food
- Other forms of harming, scratching, hair pulling or hurting themselves

Often we do not realise the power that our words have on children. Children as well as some adults can take things very personally. **But, children especially are very sensitive to some remarks like 'you are stupid, you are fat, you are clumsy'.** These remarks can powerfully undermine a child's sense of self-worth. We can use instead: *I am not pleased with your behaviour, come over and let's talk about it...* This gives us access to a better state, to intelligently communicate our feelings and distresses. It also gives a message to the child that it is not them but their behaviour what needs to be changed.

SOCIETY AND ED: WE ARE *ALL* MEMBERS OF SOCIETY

Today we are flooded with messages telling us that we are unacceptable and unlovable and unhealthy unless we somehow manage to achieve a body size and shape which is biologically sustainable for only a handful of human beings. This message is reinforced in hundreds of ways through the mass media, advertising, entertaining industries, health professionals and many well-meaning people. The cultural obsession with losing weight has reached a level which is seriously hurting millions of people.

Our youth today is struggling with a major health crisis that is dominating their lives in detrimental ways. We live in a culture that promotes destructive values and tells us that our bodies are wrong. We are creating an environment in which our children are afraid to eat. **We need to allow our children to eat without fear.**

We do not deal with promoting healthy eating in healthy ways. New approaches are needed to deal with these issues in less destructive and emotionally healthier ways. People have lost the ability to trust their bodies and listen to their body's signals and needs. We mostly eat what is pushed on us by economically driven advisers, and marketing diagnoses.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Most professionals deal with only a few elements of the problem. For example, many obesity specialists sometimes focus so narrowly on making weight loss happen, they seem unaware of the consequences of their actions. It is difficult to find specialists that address the whole picture. **Weight is the new scapegoat blamed for everything from back pain, cancer and soon it could be even toothache.**

Our modern culture is young-person centred, but in many ways it does not provide an environment that is nurturing or emotionally supportive and physically healthy development of our next generation. In fact, the opposite, it nurtures serious problems, it creates epidemics of ED. Forms of Eating Distress like Anorexia and Bulimia are becoming accepted as weight control. **With such a strong focus on thinness and appearance, body image becomes central to our feeling of self-esteem and self-worth, over-shadowing personal qualities and achievements in other aspects of our lives.**

Boys and girls talk more than ever how they look and how much they hate the way they look. During school lunches they watch one another to see who is eating less. Subjects like cellulite, flat stomachs and fat thighs, new diets and exercise become the highlights of conversations and dictate how they feel about themselves.

MALES AND ED

Men are also affected by the pressures to shape their bodies to match current ideals. They are increasingly being targeted by fitness, muscle and body sculpting advertisers; only physical perfection is now acceptable. They strive to fit a shape that is not too big or too thin.

Magazines, newspaper, television, radio programmes and books describe eating distress as mostly a female's issue. However, males develop this condition as well and not only in recent times. This was observed over three hundred years ago. In 1964, London physician Richard Morton, for the first time, reported a case of anorexia nervosa in a 16-year old male.

Admitting to having an eating disorder is difficult for anyone, but even more difficult for males due to the perceived notion that only females suffer from the illnesses. The National Centre for Health Statistics (USA) states that 48% of males are trying to lose weight as compared to 64% of females. Men undergo 25% of all cosmetic surgeries in USA. Male sufferers have been overlooked and understudied. Many programs are treating female sufferers only. Males struggling with eating distress were often teased more about their bodies while growing up.

In the last twenty years, the reported cases of males with eating distress have been steadily increasing. Media and professionals are paying more attention to this issue. Men's bodies are more frequently the targets of advertising campaigns; leanness for men is increasingly being emphasised, and the number of male dieters and males reporting eating disorder continues to rise.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Very often men with eating disorder are intensely athletic and to have begun dieting in order to attain greater sports achievement or from fear of gaining weight because of sport. Many men may fit another proposed but not yet accepted diagnostic category, referred to as *compulsive exercise*, *compulsive athleticism*.

HOW CAN TEACHERS HELP?

Teachers can play an important role in recognising the early signs of ED. It is difficult to recognise ED in the early stages and very often the first people to see the early signs are school staff, youth workers and guidance counsellors. Schools need to provide an intellectually stimulating environment needed for learning where our children feel safe and accepted. This needs to be safe from too much academic pressures, violence, harassment and bullying.

Students suffering from ED are very sensitive, and very prone to stress out. Continuous assessment and project work can create an enormous amount of pressure. Often they do not know their own limitations and have very high expectations and are afraid to slow down or give up some activities. They are often perfectionists and they need to learn to believe that their best is good enough.

Teachers need to be aware of the expectations put on their pupils. While it's good to encourage pupils to reach their maximum potential, in this competitive environment the pressure can become too much. Pupils need to learn to realise that no one is brilliant at everything and to have confidence about coping with not achieving when necessary. Pupils with this condition need to be encouraged to set their own goals rather than accepting those imposed on them.

Physical educators, science teachers and social studies teachers should learn about and teach how our culture wrongly promotes

- Prejudice against overweight people
- The conviction that 'thinness is goodness'
- The belief that people should sacrifice their health in desire for beauty

In schools it is very important to emphasise self-esteem, self-assertion and communication skills. These strengths will inoculate children against pressure they experience to change and harm their bodies in pursuit of images of 'perfection' and 'goodness'.

Sponsored fasts, which have become very popular as ways of raising money for certain charities should not be promoted. Students who are suffering or in recovery from ED may find it difficult to watch fellow peers abstaining from food when perhaps they are unable to participate. These fasts may have a very negative effect on a student with an ED.

RECOVERY

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

The first step to a successful journey to help someone recover from eating distress is to expand one's **knowledge of the condition**. Not understanding is dangerous. Many people claim to know a lot about this disease, but often it is just knowledge of the medical definitions.

If we want to help somebody recover from ED we need to know what contributes to the development and maintenance of Eating Distress. We cannot simply blame society because we are a part of it. That means that we may hold certain societal messages without our conscious awareness. We need to become aware of how society influences our thinking about ourselves.

The body is often described by the media as an instrument. The body is a possession to be moulded by us. Our bodies are products of a consumption society. This view of our bodies leads to; low frustration tolerance, instant intimacy, and no social responsibility, an 'I see I want it' attitude.

Many people put a lot of energy into finding out the reason why a person has an eating distress. This logical thinking reasons that by rectifying the causes, a person will recover. This is in many cases waste of energy. When we work with a person with an eating disorder all our energy needs to go into finding out the **reasons for recovery**.

For years eating distress was treated as if it was weight problem. Often we heard that eating disorders are chronic, progressive, addictive illnesses that can be arrested, but not cured. Sufferers went on different diets to put on or to lose weight. But, abnormal food patterns are only symptoms of underlining issues.

Recovery means learning how to deal with life's problems in constructive ways without turning to food or starvation. Recovery involves learning how to get more out of life while learning how to balance life with other things like friendships, work, hobbies and interests. Anything that offers hope has the potential to heal. Hope is more powerful than any other therapeutic technique.

Recovery is about making better choices in life. It is important to learn not to be afraid of recovery. Instead, focus on learning how to enjoy the journey to find the real self. Recovery involves letting go of the desire to be rescued and taking responsibility to find out who we are.

Recovery means something else to every person. But in our experience, we found that nearly everybody's recovery includes the points listed below.

FOUR LEVELS OF RECOVERY

Emotional level - A person learns to get in touch with their feelings and starts to express them appropriately. It is a stage when person starts to feel a range of emotions like fear, sadness and anger as well as love and joy. A person is able to set appropriate boundaries with people and to relate to people in close and intimate ways.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Physical level - A person learns to feel comfortable with her/his body. Health will take on importance. A person starts to enjoy and to be proud of their sexuality. However, by dwelling on only the physical aspects, a person cannot change and develop as valuable human being. A person may not be able to give up their behaviour until they learn to deal with stressful situations.

Mental level - A person builds a belief system to support and work for him /her. He/she learns to use their intellect to express themselves clearly. A person becomes open to new ideas. Most people with eating distress appear to be very bright. However, because of the energy necessary to successfully maintain their condition, they don't use enough in other intellectual pursuits.

Spiritual level - A person learns to discover his or her own worth. He/she feels connection to their spiritual source. They learn to spend time quite and alone just 'being'. When they get in touch with the spiritual aspects of themselves, it will help them to overcome their distress.

RECOVERY IS:

1. Gaining freedom from food obsession
2. Gaining freedom from body obsession
3. Learning to know yourself
4. Learning to be aware of yourself
5. Learning to accept yourself
6. Learning to believe in yourself
7. Emphasising honesty
8. Living in the present
9. Taking care of your physical health
10. Changing and being open to forming new relationships
11. Giving to others and learning to receive
12. Being able to talk about your real feelings
13. Having clarity of thought
14. Increasing spirituality
15. Gaining the ability to have real fun in life
16. Loving yourself the way you are

POPULAR MYTHS ABOUT EATING DISTRESS SUFFERERS

MYTH

People who suffer with ED are attention-seeking. They are vain, selfish, self-absorbed and manipulate people around them.

FACT

They are extremely caring people who do not believe in their qualities. They crave the approval of others more than the average person. They have a great need to please people, but often go about it the wrong way.

**ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT**

MYTH

They are selfish and self-obsessed.

FACT

They have no sense of self. Their self-esteem is often below zero and their self-harming behaviour is the only way they can communicate and voice their existence.

MYTH

People with ED must come from dysfunctional families.

FACT

The main reason for ED is super-sensitivity and society changes. Blaming families brings about more guilt and is extremely counter-productive and harmful. Families are over-blamed in ED theories. If they were properly coached they could save lives.

MYTH

They don't want to grow up.

FACT

They don't know how to grow up.

MYTH

Eating disorders are contagious.

FACT

ED symptoms only become apparent as a result of suffering from within, not outside Influences.

MYTH

It's a question of brain chemistry.

FACT

It's a question of distorted thinking.

MYTH

Sufferers should just pull themselves together.

FACT

They cannot do so without help.

MYTH

It's the result of trauma; sexual, emotional, physical abuse.

FACT

It's the result of a very complex set of experiences in the supersensitive person's life.

MYTH

Only 60% fully recover.

FACT

Full recovery is possible for everybody.

**PSYCHOLINGUISTIC MOTIVATIONAL EDUCATIONAL MODEL AS A TREATMENT
FOR OBESITY**

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

People tend to imagine those who suffer from eating disorders as emaciated teenagers unable to grow up. However, the facts are quite different. A very large number of our clients suffer from obesity and according to our statistics more than 45% of those who suffer from obesity also suffer from eating disorders.

Our experience has shown us that information alone does not deliver a change in eating patterns or lifestyle habits. Basically, people absorb the information but ignore it. Obese people are viewed and almost universally treated with disdain. This intensifies their problem and, as result, many turn to periods of bulimia and starvation in desperate attempts to deal with their weight problem.

It is heart-wrenching to listen that being obese causes absolute misery. It ruins people's lives, it occupies all their energy and it is a major hazard to emotional well-being. The message to eat less and exercise more is a typical approach taken in dealing with the chronically overweight. Little is taken into account of their mental approach to losing weight and keeping it off. Most sufferers know all the theories connected with weight loss. They are the best dieters in the world, they just do not know how to manage their body and their emotional connection. People with weight problems use their body as an emotional punching bag; as a coping mechanism for life situations.

Each person's attitude towards food is influenced by their attitude towards food in the home environment. If one parent is always dieting and is always dissatisfied with her or his body, subconsciously the child absorbs this and regards it as normal. The never-ending supply of diets aimed at vulnerable sufferers will shift weight in the short term, but does not solve the problem of an unhealthy attitude to and a distressed relationship with food.

A very important part of work with weight issues is motivation. A person needs this strategy when they want results, but it is hard to get excited about the process. There are two things that motivate people - one is inspiration and the other is desperation. Everyone uses both to some degree. In coaching people, it is important to use both motivations, *away* from and *toward*.

In 1994, the DSM-IV introduced criteria for *binge eating disorder*, BED. The criteria for BED states that an episode of binge eating is characterised by both of the following; *eating in a discrete period of time, an amount of food that is definitely larger than most people would eat in similar period of time under similar circumstances and a sense of lack of control over eating during the episode*. This establishment of criteria for BED in the field of weight management is important as it acknowledges that the manner in which a person uses food and reason for consuming food could be just as important to the disease presentation as the total energy consumed.

Recognising BED is not as simple as it appears. Clients with BED often seek weight-loss counselling, and a better screening service is required.

THE POWER OF WORDS

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

The way in which a person thinks influences the way that person feels. If we want to change a feeling, we must first change the thinking. If we want to help a person recover from an eating distress, we need to learn the *language of eating distress*. We need to be aware that sufferers will interpret everything that is said in their language of negativity. We need to focus attention on what to do and how to do it, rather than on problems, excuses and explanations.

Instead of hearing clear encouraging messages promoting health and well-being, sufferers hear an endless parade of 'good foods' versus 'bad foods', negativism and a lot of contradictions.

Sometimes, without realising it, certain statements we make about food, and weight, etc. can increase others' negativity. It is important to be aware of this and remember that we may contribute to someone's ED by:

- Admiring thinness/Admiring weight loss diets
- Encouraging perfectionism
- Encouraging someone to pursue a diet or depriving themselves of "fattening" food.
- Making negative comments about your own or somebody else fatness/ Disapproving fatness in general
- Making statements which presume that bigger people should lose weight
- Making statements which presume that bigger people eat too much
- Referring to "good" and "bad" foods
- Admiring excessive exercise

SOCIAL PRESSURES PROMOTING DIETARY RESTRAINT:

Studies in the USA have shown that cardiovascular and metabolic fitness levels are more important than weight and body mass when it comes to overall health and mortality rates. In a study carried out by Steven Blair, at Dallas' Cooper Institute which involved more than 70,000 people, it was discovered that BMI appears to have no relevance to health whatsoever. Obese people who engage in moderate levels of physical activities have around one-half the mortality rate of sedentary individuals who maintain supposedly 'ideal' weight levels.

Low fat diets are not appropriate especially for children or elderly, according to Professor Alfred Harper of Wisconsin University. These guidelines do not ensure that the growth and development of children will not be impaired. The assumption that limiting fat intake will provide healthier lives has not been validated by research. The current drop in fat content has not been accompanied by a decrease in the number of overweight people, as expected, but rather by sharp increase. Low fat foods may be making people fatter because they lessen satiety. Professor Harper argues that blaming fat for the increase in chronic disease is an unproven myth.

A study carried out in London University also confirmed the negative effect of repeated weighing on the psychological state. Repeated weighing encourages the individual to focus on body weight. This accelerates any existing self-criticism

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

resulting in changes in mood and self-esteem. Changes in depression and body dissatisfaction in the weighed group reflected their actual change in body weight.

The French are far healthier than other nationalities. They spend a lot of time eating; eat 30% more fat; do no exercise, and drink ten times more wine than Americans and have one of the lowest weights in Western world. This leads us to believe that **the calorie-counting approach is not working.**

The times people eat and how they eat is more important. It has been established that the absorption of carbohydrates, fats and protein varies considerably depending on the time of the day, even the time of the year.

Scientists have also established that the theoretical calculation of calories never considers the conditions under which fats and carbohydrates are absorbed into the intestines. These conditions change. **Calorie-reduced foods, the classical diet, is usually the beginning of lifelong obesity.** Particularly if the first diet is followed by a second, third, etc. *Calorie counting is the wrong approach, a dead end. It ignores too many details, it has been established that the absorption varies considerably depending on time of the day.* (Dr. Montignac)

If we starve our bodies by giving them less energy, they will immediately use every opportunity to establish new (fat) reserves. Today, we call this 'yoyo' effect. So it is important to eat three regular meals a day and three snacks and not skip any meals!!!

In laboratory tests, animals have shown that if they receive an equal daily amount of food, once in the evening, they become overweight. On the other hand, animals who receive a daily ration divided over five or six meals, do not gain weight. Statistics show a frightening picture. People who go on one diet after another finally end up with much more fat tissue than they ever had before beginning the first one. A person who has made his/her way into this vicious circle of deprivation can never lose another gram. The metabolism adjusts itself to a decreased number of calories.

A very small number of overweight people are eating too much (only 15%). According to French statistics, 35% of overweight people eat normally. 50% eat very little, around 800 calories, a day, but binge occasionally. A person eating so little is damaging his/hers health. He/she usually suffers from a deficiency in essential fatty acids, mineral salts, vitamins and trace elements. This is then manifested in tiredness, a weakened immune system and/or depression.

MORE MIND THAN BODY:

Excessive weight loss involves more 'mind' than 'body'!

The conscious 'you' and subconscious 'you' both need to want the same thing. The secret of successful slimming is not will power. It is our imagination, which we reach via our subconscious mind. The key to reaching our subconscious is strong, frequent visualisation of success. And frequent repetition of our affirmations. This conditions our subconscious to want to produce a slim and healthy body. And our subconscious will find ways that will automatically bring that desirable result. A positive self-approving frame of mind is essential. If we feel good we look good.

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

Sometimes even small changes create a dramatically new result. They can turn a depressing negative into new possibilities. The difference between people who keep the weight off, and those who don't, is their attitude and motivation. They are the ones who create new perspectives on old and incorrect beliefs and turn problems into challenges and participate in their recovery.

ACTIVITY DISORDER

We are living in the '*fitness*' generation. We are encouraged to eat low fat food, increase fibre, reduce intake of sodium and have a healthy exercise regime. But what is health and what is fitness?

Fitness - the physical ability to perform athletic activity

Health - the state when all systems of the body (nervous, muscular, circulatory, digestive, lymphatic, hormonal...) are working in an optimal way.

Exercise may seem a healthy activity but it is used by some people with an ED in an obsessive way to control their weight. A person suppresses the signals of the body's limit indicating overwork. While moderate amounts of exercise can reduce depression, depression also can be product of over-training.

Many people with ED exercise to such a degree that there is little time left for friends, families, schoolwork and other aspects of life. Some experience a feeling of superiority from being able to exercise more than other people. **Exercise addiction sufferers often have family or other social difficulties.** Very often exercise dependency is an avoidance mechanism - '*I don't want to go home, I will exercise instead*'. Exercise in many cases is a replacement for destructive behaviours.

WAYS TO RECOGNISE AN OBSESSION WITH EXERCISE

1. Do I pass up social activities and spending time with my family and friends rather than miss workout?
2. Do I schedule my day around my exercise rather than my exercise around me schedule?
3. Is exercise used as a means to burn calories and lose weight rather than to have fun, enjoy body movements and master or maintain physical and emotional health?
4. Is exercising a way to purge unwanted thoughts and avoid unpleasant feelings rather than express them?
5. If I miss my workout, do I feel anxious, guilty, angry or fat?
6. Do I determine how much exercise I do in terms of how much food I have eaten?
7. If I miss workout do I deny myself food?
8. Do I ignore injury, fatigue and pain?
9. Is body size always on my mind?

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

ED continues to be on the increase among people involved in athletics because of the great emphasis on athletes to be thin. According to a 1992 American College of Sports Medicine study, 62% of females in sport like figure skating and gymnastics. Gymnasts Kathy Johnson, Nadia Comaneci and Cathy Rigby have come forward and admitted to fighting ED. Cathy Rigby, the 1972 Olympian, battled ED for 12 years. She went into cardiac arrest on two occasions as a result of it.

Athletes are often willing to tolerate pain, ignore fractures, torn ligaments and the loss of their menstrual cycle in order to achieve their goal. Food becomes the enemy instead of an avenue to enhance health and performance and over-exercising becomes the means to purging calories and negative emotions.

Many athletes fall in to the trap of ED in order to please coaches and judges. Many coaches pressure athletes to lose weight. This could cause an athlete to resort to dangerous methods of weight control and can do serious emotional damage to them.

WHAT COACHES CAN DO TO PREVENT EATING DISTRESS IN THEIR ATHLETES

1. Instruct coaches and trainers to recognise the signs and symptoms of Eating Distress and understand their role in helping to prevent them. Those with ED often hide their symptoms to avoid calling attention to them. They are often aware the behaviour is abnormal.
2. Provide athletes with accurate information regarding weight loss, body composition, nutritional and sport performance in order to reduce misinformation. Challenge practices that are unhealthy and even counterproductive. Be aware of local professionals who will help educate the athletes.
3. Emphasise the health risk of low weight, especially for female athletes with menstrual irregularities or amenorrhoea. The athlete should be referred for medical assessment in these cases.
4. Refer to a sport psychologist or other therapist skilled at treating ED if an athlete is chronically dieting and exhibits mildly abnormal eating. Early detection increases the likelihood of successful treatment. Left untreated, the problem may progress to a serious condition.
5. De-emphasise weight by not weighing athletes and by minimising (eliminating) comments about weight. Instead, focus on other areas in which athletes have more control in order to improve performance, i.e. focus on strength and physical conditioning, as well as the mental and emotional components of performance.
6. Do not assume that reducing body fat or weight will enhance performance. Many studies showed this does not apply to athletes. Improved performance should not be at the expense of the athlete's health.
7. Understand why weight is such a sensitive and personal issue for many people. Since weight is emotionally charged for many, eliminate derogatory comments or behaviours, no matter how slight, about weight. If there is concern about an athlete's weight, the athlete should be referred for an assessment to a therapist skilled in treating ED.
8. Sport personnel should explore their own values and attitudes regarding weight, dieting and body image, and how these values and attitudes may

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

inadvertently affect their athletes. They should understand their role in promoting a positive self-image and self-esteem in their athletes.

9. Take warning signs seriously. Take ED behaviour seriously. There is a high mortality and very high suicide rate for those who suffer.

SELF-HARM

Self-harm is widely misunderstood and there are many myths associated with it, which can make it difficult for people to ask for help. When people hear about cutting, using knives, razors, or shards of glass to cut their skin and draw blood, there is a reaction of horror, disgust, and instant judgement. The reasons for such reaction are complex. One of the explanations is that we, in Western culture are not able to attach an appropriate meaning to the activity of self-harm.

The first published reference to cutting is in the New Testament, Gospel of Mark. Mark describes a man living in a graveyard who is believed to be possessed cutting himself deliberately with stones.

Islamic healers in Morocco work themselves into a ritual frenzy and slash open their heads. Sick people attending the ceremony dip bits of bread and sugar cubes in the healer's blood and eat them. For this group, blood from the healer is believed to be potent medicine.

Not until 1938 did Karl Menninger attempt to delineate self-mutilating behaviour into separate categories, although he linked them together by a psychoanalytic concept. Since mid 1800's, psychiatrists have published sporadic case reports and clinical studies on this topic, but the subject failed to achieve either academic acceptance or public acknowledgement. Only in 1993 was the subject of cutting given a prominent position, as a cover story in a popular magazine.

Self-injury is ultimately a destructive coping mechanism where the abuser is also the abused. It can be defined as the attempt to deliberately cause harm to one's body. It is a deliberate, direct, non-suicidal destruction or alteration of one's body tissue. Victims mutilate themselves in attempt to cope with their troubled lives. It is a strangely effective coping method for dealing with an inner pain, so overwhelming it must be brought to the surface.

It can provide the necessary 'buzz' or element of distraction for many people who need to block out painful feelings that threaten to consume them. This behaviour can become an overwhelming preoccupation and a person can become addicted to their self-harm.

It is a hidden distress. Many people believe that they are the only ones who hurt themselves in this way. The distress incites feelings of fear and shame and people often keep it a secret for number of years.

Self-injury, self-mutilation, cutting, delicate cutting or self-harming, auto-aggression are all names given to this condition. It takes many forms of presenting, like cutting the skin with razors, broken glass or other sharp objects, it could be breaking their

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

own bones, head-banging, scratching or bruising, hitting the body with objects, skin-picking, burning or hair-pulling. It is generally used as a means of coping with overwhelming psycho-physiological arousal. It expresses emotions. It helps the sufferer to deal with feelings of reality or numbness, to make flashbacks stop, to punish the self and stop self-hating thoughts.

It is more about relieving tension or stress than it is about anything else. Most people who harm themselves tend to be perfectionists who are unable to handle intense feelings. They find it very hard to express their emotions in any other way. They have a dislike of themselves and their bodies and self-injury is a way of punishing themselves and of expressing their feelings and emotions.

People who self-mutilate are more than their behaviour. Their lives are infinitely richer; their stories are more complex than that single label might indicate. When people hear about self-harm, they tend to place labels on the victim as being psychotic or crazy, which is why so many people find it very hard to come forward to ask for help.

Until society dispels the myths surrounding this condition through education, sufferers will continue to isolate and keep this mechanism to themselves letting this form of abuse to continue in secret.

HOW TO HELP

- Show that you care about the person
- Offer compassion and respect
- Help the person to build a support network around them
- Tell the victim that this condition can be cured and it is alright to talk about it
- Remind them that they are not alone
- Help them to express their feelings, memories and needs, other than through self-harm
- Don't look on stopping self-harm as the most important goal. Although a person may make great progress in many other areas, they still may need self-injury as a coping mechanism
- Understand that recovery can take a long time to be achieved
- Encourage each small step the person takes in leaving this condition behind
- Look for support yourself

**ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT**

Present research Conducted by the Marino Therapy Centre

**Public Awareness of Eating Distress in Ireland
Number of people surveyed - 2157**

In the present study we used a survey method with descriptive approach. The data was collected from a group of participants using a self-report questionnaire. The format of the questions was fixed response. The method was descriptive in that it aimed to ascertain a profile of the participants surveyed.

The participants in this study included teachers, civil servants, health professionals, employees of psychiatric hospitals, owners of health food stores and students, both male and female, aged 18 - 60 years old. 4800 questionnaires were distributed and 2157 have been returned completed (45%).

A self-report questionnaire was used which has been devised specifically for this purpose. SPSS 6 was used to analyse the data. Frequency distributions were obtained for all data.

How much do you know about Eating Distress?

- A lot - 13%
- Something - 36%
- Very Little - 32%
- Nothing - 19%

When you hear about Eating Distress in the media how do you feel people with ED are treated by them?

- Balanced way - 21%
- Unbalanced way - 31%
- Impartial way - 19%
- Prejudiced way - 16%
- Discriminatory way - 7%
- None of these - 6%

The fashion industry is a significant contributor to Eating Distress:

- Strongly agree - 41%
- Agree - 44%
- Neither agree or disagree - 9%
- Disagree - 2%
- Strongly disagree - 2%
- Don't know - 2%

People with Eating Distress are hard to talk to:

- Strongly agree - 5%
- Agree - 28%
- Neither agree or disagree - 24%
- Disagree - 24%
- Strongly disagree - 6%
- Don't know - 13%

**ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT**

People with Eating Distress are not to blame for their condition:

- Strongly agree - 14%
- Agree - 31%
- Neither agree or disagree - 30%
- Disagree - 17%
- Strongly disagree - 3%
- Don't know - 5%

They can pull themselves together if they want to:

- Strongly agree - 4%
- Agree - 20%
- Neither agree or disagree - 15%
- Disagree - 36%
- Strongly disagree - 19%
- Don't know - 6%

Do you think medical treatment can improve condition?

- Strongly agree - 12%
- Agree - 44%
- Neither agree or disagree - 16%
- Disagree - 17%
- Strongly disagree - 3%
- Don't know - 8%

Most people make full recovery:

- Strongly agree - 2%
- Agree - 15%
- Neither agree or disagree - 23%
- Disagree - 36%
- Strongly disagree - 5%
- Don't know - 19%

GP's do not give enough support:

- Strongly agree - 16%
- Agree - 34%
- Neither agree or disagree - 23%
- Disagree - 13%
- Strongly disagree - 2%
- Don't know - 12%

Tranquilliser or anti-depressants can help a person with ED:

- Strongly agree - 2%
- Agree - 12%
- Neither agree or disagree - 13%
- Disagree - 35%
- Strongly disagree - 15%
- Don't know - 23%

The media has a lot to answer for in their coverage of ED:

- Strongly agree - 27%
- Agree - 42%
- Neither agree or disagree - 14%
- Disagree - 10%
- Strongly disagree - 1%
- Don't know - 6%

**ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT**

If you felt you were suffering from ED, what would you do?

- See your GP - 24%
- Go to the hospital - 1%
- Go to the psychiatrist - 4%
- Ring a Help-line - 16%
- Try to pull myself together - 23%
- Talk to a friend /relative - 30%
- Other - 1%
- Don't know - 1%

Which of these do you know with ED?

- Myself - 6%
- Spouse/Partner - 1.5%
- Girlfriend/Boyfriend - 4%
- Father - 0.5%
- Mother - 2%
- Brother - 1.5%
- Sister - 6%
- Other relative - 15%
- Friend - 35%
- Some in work - 13%
- Other - 10%
- No one - 5.5%

Recovered or high stage of recovery people's answers (100):

How much do you know about Eating Distress?

- A lot - 90%
- Something - 10%
- Very Little - 0%
- Nothing - 0%

When you hear about Eating Distress in the media how do you feel people with ED are treated by them?

- Balanced way -0%
- Unbalanced way -34%
- Impartial way - 37%
- Prejudiced way - 16%
- Discriminatory way - 13%
- None of these - 0%

The fashion industry are a significant contributor to Eating Distress:

- Strongly agree - 66%
- Agree - 25%
- Neither agree or disagree - 8%
- Disagree - 12%
- Strongly disagree - 0%
- Don't know - 0%

People with Eating Distress are hard to talk to:

- Strongly agree - 0%
- Agree - 10%
- Neither agree or disagree - 21%

**ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT**

- Disagree - 33%
- Strongly disagree - 36%
- Don't know - 0%

People with Eating Distress are not to blame for their condition:

- Strongly agree - 47%
- Agree - 47%
- Neither agree or disagree - 6%
- Disagree - 0%
- Strongly disagree - 0%
- Don't know - 0%

They can pull themselves together if they want to:

- Strongly agree - 0%
- Agree - 0%
- Neither agree or disagree - 0%
- Disagree - 57%
- Strongly disagree - 39%
- Don't know - 4%

Medical treatment can improve condition:

- Strongly agree - 0%
- Agree - 2%
- Neither agree or disagree - 16%
- Disagree - 59%
- Strongly disagree - 18%
- Don't know - 5%

Most people make full recovery:

- Strongly agree - 13%
- Agree - 87%
- Neither agree or disagree - 0%
- Disagree - 0%
- Strongly disagree - 0%
- Don't know - 0%

GP's do not give enough support:

- Strongly agree - 15%
- Agree - 47%
- Neither agree or disagree - 20%
- Disagree - 14%
- Strongly disagree - 0%
- Don't know - 4%

Tranquilliser or anti-depressants can help a person with ED:

- Strongly agree - 0%
- Agree - 0%
- Neither agree or disagree - 6%
- Disagree - 62%
- Strongly disagree - 32%
- Don't know - 0%

The media has a lot to answer for in their coverage of ED:

- Strongly agree - 4%
- Agree - 87%
- Neither agree or disagree - 7%
- Disagree - 0%

ANOREXIA AND OVER-EATING: 2 SIDES OF THE SAME COIN
THE ROLE OF FAMILY AND PROFESSIONALS IN ED TREATMENT

- Strongly disagree - 0%
- Don't know - 2%

If you felt you were suffering from ED, what would you do?

- See your GP - 16%
- Go to the psychiatrist - 4%
- Go to the hospital - 0%
- Ring a Help-line - 50%
- Try to pull myself together - 0%
- Talk to a friend /relative - 30%
- Other - 0%
- Don't know - 0%

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