DEVELOPMENT OF THE NOVA LUZ GAME FOR USE IN PSYCHOTHERAPY IN CASES OF FOOD DISORDERS[1]

DESENVOLVIMENTO DO JOGO NOVA LUZ PARA UTILIZAÇÃO NA PSICOTERAPIA EM CASOS DE TRANSTORNOS ALIMENTARES

DESARROLLO DEL JUEGO NOVA LUZ PARA USO EN PSICOTERAPIA EN CASOS DE TRASTORNOS ALIMENTARIOS

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ABSTRACT: The cognitive-behavioral approach is based on the cognitive model associated to specific techniques and strategies, aiming at modifying thoughts, beliefs and dysfunctional behaviors related to the patient's suffering or emotional disorder. Although CBT has become accepted as one of the main methods of treatment for eating disorders, studies are still growing in Brazil. This article proposes the development of the Nova Luz game as a resource to be used in psychotherapy in cases of Eating Disorder. The construction was done according to the existing literature and the acquired knowledge. Thus, it achieved the purpose of creating an artifice that would promote moments of psychoeducation and contribute to the investigation of important factors for the psychotherapeutic process, in a less tense and more spontaneous way during the session, when the patient brings the complaint related to food issues.

KEYWORDS: Cognitive behavioral therapy. Eating disorders. Game.

***RESUMO**: A abordagem cognitivo-comportamental se baseia no modelo cognitivo associado às técnicas e estratégias específicas, visando à modificação de pensamentos, crenças e comportamentos disfuncionais, relacionados ao sofrimento ou transtorno emocional do paciente. Embora a TCC tenha se tornado aceita como um dos principais métodos de tratamento para transtornos alimentares, estudos ainda estão em crescimento no Brasil. O presente artigo propõe o desenvolvimento do jogo Nova Luz como recurso para ser utilizado em psicoterapia nos casos de TA. A construção foi feita de acordo com a literatura já existente e o conhecimento adquirido. Assim, alcançou o propósito de criar um artifício de forma que promovesse momentos de psicoeducação e contribuísse para a averiguação de fatores importantes para o processo psicoterapêutico, de maneira menos tensa e mais espontânea durante a sessão, quando o paciente traz a queixa relacionada a questão alimentar.*

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PALAVRAS-CHAVE*: Terapia cognitivo-comportamental. Transtornos alimentares. Jogo.*
RESUMEN: *El enfoque cognitivo-conductual se basa en el modelo cognitivo asociado a técnicas y estrategias específicas, con miras a la modificación de pensamientos, creencias y comportamientos disfuncionales, relacionados con el sufrimiento o trastorno emocional del paciente. Aunque la TCC se ha aceptado como uno de los principales métodos de tratamiento para los trastornos alimentarios, los estudios aún se están desarrollando en Brasil. Este artículo propone el desarrollo del juego Nova Luz como recurso para ser utilizado en psicoterapia en casos de TA. La construcción se realizó acorde con la literatura existente y los conocimientos adquiridos. Así, logró el propósito de crear un artificio de manera que propiciara momentos de psicoeducación y contribuyese a la investigación de factores importantes para el proceso psicoterapéutico, de forma menos tensa y más espontánea durante la sesión, cuando el paciente trae la queja relacionada con el tema alimentario.*

PALABRAS CLAVE: *Terapia de cognitivo-conductuales. Trastornos de la alimentación. Juego.*

Introduction

Nowadays, food culture is characterized by the exaltation of the great amount of food, provided that with low cost and preferably in a short space of time. Thus, casters are glorious, aiming at personal profit, eating in large quantities, always served and using the benefit of the cost "in account". Continuing with this idea of cost, there are also combos and promotions, which have expanded with the advent of mobile applications, with some offering the delivery service, pleasing many users due to convenience.

Therefore, according to the law of supply and demand, the tendency is that this behavior, the valorization of food in great quantity and price, continues to be incorporated amid society. On the other hand, there is a pattern of beauty dictated to the collective that exalts the lean body, again highlighted by technology and social networks, representing self-discipline. Thus, one can perceive the contradiction and social pressure that involves the perception of the image and behaviors about food (OLIVEIRA; HUTZ, 2010).

One possibility to experience pleasure is through food, sometimes going beyond the level of eating to feed, and can be clearly exemplified in the food compulsion, which is tied to the momentary lack of control, surrendering, either to the pure pleasure of eating or to mask bad feelings and experiences. However, the guilt that follows can lead to compensatory behaviors related to a bulimic picture (BORGES *et al.,* 2006). Food can also be seen as a villain, choosing to avoid it at any and all costs, because it prevents one from reaching what is thought to be the ideal body, in the case of anorexia, an unattainable ideal.

We live in a time of exposure, once again with regard to modernity and technology. The social networks favor the comparison with the next, in this world, what matters is the visual, the image, the vanity, the amount of followers and tanned. What matters in reality is to be accepted. I accept even for unknown people, even with the photoshop resource, so that it appears thinner, with a more defined belly, refined face, buttocks and bigger breasts, because it is like this the idealized body, and the will of being this way increases among several users. The media, in great part, recognizes and reinforces such behavior.

Medical complications can arise from malnutrition and compensatory purgative behaviors, such as anemia, endocrine disorders, osteoporosis and hydroelectrolytic disorders (especially hypokalemia, which can lead to cardiac arrhythmia and sudden death), among others. Clinical complications are mainly due to compensatory maneuvers for weight loss, such as: erosion of teeth, enlargement of parotides, esophagitis, hypopotassemia and cardiovascular alterations, others (LEAL; CABRAL, 2002).

About the history of the interest of psychology in the face of eating disorders, it occurred in the 40's (OLIVEIRA; DEIRO, 2013), after that, other approaches were also highlighted due to differences of conceptions about the conduct of the subject. Still, authors argue that more studies are needed on the subject.

It can be observed that people affected by eating disorders usually feel a deep guilt for being in such a situation, so the social cycle often takes time to notice the symptoms and that this person voluntarily seeks professional help.

Once in the office, the delicate subject hovers, loaded by a feeling of shame, however, it is fundamental to evaluate the symptoms, thoughts and behavior of the patient. For this evaluation to be done in a less conservative way, playing can be a solution, because this strategy connects the outside world with the inside, as Affonso (2012) defends, being widely used as strategies in children's psychotherapies, including the cognitive-behavioral approach on which the work is based. However, it is proposed that the playfulness be experienced for other phases of development, so that the complaint brought by the patient regarding eating disorder (AT) can be best illustrated.

Therefore, this paper aims to address the complaint of eating disorder, found in psychotherapy offices, as well as the cognitive behavioral strategies used, guiding the development of the game " Nova Luz ". Intentionally elaborated for the use in psychotherapy sessions, having as proposal the evaluation of symptoms, thoughts and dysfunctional behaviors, talking about self-esteem, favoring the patient-therapist relationship and promoting moments of psychoeducation.

For this purpose, a brief history of eating disorders will be initially presented, recapturing the first records found on their incidence, definitions and symptoms of anorexia, bulimia and eating compulsion, involving the multifactorial etiology and disserting on the course of CBT related to the eating disorder topic.

Eating Disorders

According to the American Psychiatric Association, eating disorders are understood by the subject's food-related dysfunction in intensity, frequency and behaviors resulting from this relationship, with damage to physical health and psychosocial functioning. They are understood by: Anorexia, Bulimia, Eating Compulsion, Pica and Restrictive / Avoidance Disorder, while the first three cited present a concern with the body, slimness and body dysfunction, motivating the efforts and dysfunctional behaviors (DUCHESNE; ALMEIDA, 2002).

The word anorexia comes from the Greek A (negative, without) + OREXIS (appetite, desire) meaning without appetite. Although studies began around the 17th century, cases related to the symptoms of eating disorders had appeared centuries before.

In the 3rd century, for example, they allege that there were medical reports of patients affected by what resembled anorexia, such as the case of a Buddha who sought enlightenment through starvation. Soon, anorexia was first recognized in the Middle Ages as a mysterious cause that tended to a self-imposed hunger diet with significant weight loss (OLIVEIRA, 2004). Thus, during the Middle Ages, fasting practices were understood as states of demonic possession or divine miracles. Cordás (2004, our translation) states that “In the 13th century, descriptions of women who self-imposed fasting as a way to get spiritually close to God were found in great profusion; they were the so-called anorexic saints”.

The first case record was close to nervous anorexia (NA), was made by Richard Morton, in the year 1689. The author also comments in his book “Tisiologia sobre a doença da consunção” about the mutual influence between mental and physical processes and highlights the pathogenic role of emotions, i.e., psychosomatic (CORDÁS, 2004). In a near moment, the French psychiatrist Lasègu published the article “De l'anorexie hystérique”, believing that the etiology of the disorder was hysterical, emphasizing cognitive distortions, denial, body image disorders and family involvement (CORDÁS; CLAUDINO, 2002).

In agreement with the American Psychiatric Association, nervous anorexia consists of the restriction of calorie intake in relation to needs, leading to significantly low body weight

in the context of age, gender, developmental trajectory and physical health of the individual, due to the intense fear of gaining weight or fattening, even being significantly underweight. If there is disturbance in the way one's own weight or body shape is experienced, undue influence of weight or body shape on self-assessment, or persistent absence of recognition of the severity of current low body weight.

According to Cordás and Claudino (2002), the behavior of forcing vomit is ancient, and can be found early in the history of different peoples of antiquity. In ancient Egypt, a great part of Eber's papyrus is dedicated to the stimulus and virtues of the act of vomiting. Herodotus believed that the Egyptians vomited and used purgatives every month for three consecutive days, based on the judgment that "all the diseases of men come from food. In Greek medicine, Hippocrates also recommended inducing vomiting for two consecutive days every month, as a method to prevent different diseases. Even the Romans created the "vomitorium", which allowed them to overeat during the banquets, and later vomit in a place reserved for this purpose, sometimes using a bird's feather to stimulate the reflection of vomiting in the throat. Purgants were popular as early as the Middle Ages, along with emetics (medication to induce vomiting) dominated the therapeutic arsenal for many years.

However, the first description of nervous bulimia was given in 1979 by the English psychiatrist Gerald Russel. The term bulimia has a very ancient history; it derives from the Greek BOUS (ox) + LIMOS (hunger), thus designating an appetite so great that it would be possible for a man to eat an entire ox, or almost (CORDÁS; CLAUDINO, 2002).

According to the American Psychiatric Association (2014, our translation), nervous bulimia (NB) is characterized by recurrent episodes of food compulsion, which involve:

> 1. ingestion, in a given period of time (for example, within each two-hour period), of a definitively larger amount of food than most individuals would consume in the same period under similar circumstances. 2. sensation of lack of control over intake during the episode. With the presence of recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting, improper use of laxatives, diuretics or other medications, fasting or excessive exercise. Occurring on average at least once a week for three months. Being the self-assessment unduly influenced by body shape and weight.

Food Compulsion, on the other hand, qualifies for:

> 1. ingestion, in a given period of time, of an amount of food definitely larger than most people would consume at the same time under similar circumstances. 2. feeling of lack of control over the ingestion during the episode (for example, feeling of not being able to stop eating or control what and how much one is eating). Episodes of food compulsion are associated

> with three (or more) of the following: Eating faster than normal; Eating until you feel uncomfortably full; Eating large amounts of food in the absence of the physical sensation of hunger; Eating alone out of shame at how much you are eating; Feeling disgusted with yourself, depressed or very guilty afterwards. Presents a marked suffering due to food compulsion (AMERICAN PSYCHIATRIC ASSOCIATION, 2014, our translation).

It is important to emphasize that eating compulsion is not associated with the recurrent use of inappropriate compensatory behavior as in nervous bulimia and does not occur exclusively during nervous bulimia or nervous anorexia. Furthermore, the eating compulsion disorder occurs in individuals of normal weight or who are overweight and obese. It is consistently associated with overweight and obesity in individuals seeking treatment. However, it is distinct from obesity (AMERICAN PSYCHIATRIC ASSOCIATION, 2014).

It is important to highlight, as Faria and Shinoara (1998) show, that obesity is contained in the International Classification of Diseases (ICD) but does not appear in The Diagnostic and Statistical Manual of Mental Disorders (DSM) as an eating disorder.

Cognitive-Behavioural Therapy

The eating disorder clinic has gone through many changes during the last decades. Initially, the main inventions were bed rest, nasogastric feeding and a variety of pharmacotherapies, mainly directed to weight recovery (OLIVEIRA; DEIRO, 2013).

Psychoanalysis came to dominate understanding and treatment from the 1940s (OLIVEIRA, 2004) and in the following decades, a regime based on reinforcement for weight gain became popular with the emergence of behavioral treatment programs. (OLIVEIRA; DEIRO, 2013) , being, however, effective in the short term, but with a high rate of relapse. Cognitive therapies also stood out due to dissatisfaction with the strictly behavioral model. Thus, CBT has become accepted as one of the main approaches for the treatment of eating disorders (DUCHESNE; ALMEIDA, 2002). However, authors still defend the need of bad studies contemplating these areas.

The cognitive-behavioral approach is based on the cognitive model and the use of specific techniques, predominantly cognitive and behavioral, that aim at modifying the patterns of thoughts and dysfunctional beliefs that cause or maintain emotional suffering and/or psychological disturbances in the individual. It is based on the assumption that emotions, behaviors and physiological reactions are directly linked to the way the individual evaluates his experiences in the world (BECK; RUSH; SHAW; EMERY, 1997), that is, in

this perspective the individual's vision and assimilation regarding the situation becomes more important than the event itself.

Therefore, according to Beck (1997), in the cognitive model, it is possible to identify three levels of cognition: the automatic thoughts, being a more superficial and spontaneous level that appears in the mind in face of several daily situations; the intermediary beliefs, which reflect the appearance of cognitive contents in the form of rules and assumptions linked to the last and deepest level, which are the central beliefs about oneself, others and the world, which are formed from remote childhood experiences.

The importance of the empathic and welcoming posture on the part of the therapist is emphasized. Thus, through the establishment of this relationship, the collaboration and active participation of the client and the therapist is sought in the resolution of the problems addressed through goals focused on the here and now and for the identification, evaluation and modification of dysfunctional thoughts and beliefs. To achieve these goals, cognitive behavioral techniques are used, mainly thought registration, Socratic questioning and behavioral experiments (ARAÚJO; SHINOHARA, 2002). It is important to emphasize that cognitive-behavioral therapists also recognize that there are complex interactions between biological processes, environmental and interpersonal influences, in addition to cognitive and behavioral elements in the genesis and treatment of psychiatric disorders (WHRIGH; BASCO; THASE; 2008).

Cognitive-behavioral therapy (CBT) for eating disorders (AT) has developed from a systematic analysis of characteristic emotional, cognitive and behavioral disorders. The treatment programs are based, largely, on basic techniques for anxiety reduction, self-management of behavior and modifications of maladaptive cognition (CHANNON; WARDLE, 1994).

Today, one of the main representatives of the cognitive-behavioral model for eating disorders is Fairburn. Its approach relates thought, emotion and manifest behavior, and the treatment aims to make the patient examine the validity of his beliefs in the present and change dysfunctional behaviors. The most frequent cognitive processes in these settings (selective abstraction, supergeneralization, magnification, dichotomous thinking, personalization, and superstitious thinking) are defined and examined carefully in order to modify the automatic thoughts and assumptions (OLIVEIRA; DAY, 2013).

Treatment Strategies for Eating Disorders

Among the main strategies used in the mediation of AT cases according to Duchesne and Almeida (2002), there is the *Decrease of the dietary restriction*, related to the establishment of regular feeding schedules and gradual exposure to food and frequently avoided situations (GARNER; BEMI, 1985). In addition, CBT teaches patients self-control techniques to reduce anxiety, sadness, and other feelings considered facilitators for food compulsion and vomiting induction. (DUCHESNE; APPOLINARY, 2001) *Elimination of the use of laxatives and diuretics*, done gradually. *Decreased frequency of physical activity* in cases of anorexia and *increased physical activity* in cases of bulimia. Considering also the *approach of the disturbance of the body image*, being this fundamental point for the understanding of the central belief of the case. To reduce the distortion of body perception, the patient can be asked to draw how it perceives its body, looking in a mirror. Then, the therapist draws the actual silhouette, so that the patient can observe the discrepancy between the drawings. Modification of the belief system, patients with eating disorders have distorted and dysfunctional beliefs about weight, body shape, diet and personal value, which are significant for maintaining AT. One of the central distorted beliefs is that which equates personal value to weight and body shape, ignoring or not valuing other parameters. (DUCHESNE; ALMEIDA, 2002) For patients with AT, thinness would be associated with competence, superiority and success, thus becoming intrinsically associated with self-esteem (GARNER; BEMIS, 1985).

Thus, techniques such as thought registration, evidence analysis and the construction of alternative thoughts are employed. It is important to emphasize that related to food compulsion episodes is “all or nothing" thinking, which consists in thinking in absolute and extreme terms. Thus, patients with bulimia, for example, adopt inflexible dietary rules and small lapses in diet favor the total abandonment of control over the changing diet (DUCHESNE; ALMEIDA, 2002), therefore, instead of having the thought of continuing progress, they think they should start again and do not take into account the step they have already reached.

The *self-esteem approach* is remarkable due to the demystification process and the perception that this factor can and should be related to other aspects, not only related to the physical appearance; moreover, when associated to obesity and excessive attention to body shape, it is accompanied by feelings of shame and inferiority, as occurs in binge eating disorder (BED), in which there is great attention to social stereotypes (DUCHESNE; ALMEIDA, 2002).

And finally, it is necessary to *evaluate the effectiveness* (DUCHESNE; ALMEIDA, 2002), that the therapist and patient list the potentialities and difficulties of the process and the current situation, and techniques to prevent relapse should be used, which consist of patient and therapist identifying possible future difficulties and planning appropriate strategies to deal with these changes. The expressiveness of the therapeutic process, the realistic position in relation to the goal of weight, modifying beliefs related to weight and body shape, achieving a balance between self-acceptance and change (DUCHESNE; ALMEIDA, 2002).

It is relevant to analyze the groups of triggers that can initiate a eating compulsion episode, so that it is possible to work with what the patient's case may be: *Biological*, such as the emptiness in the stomach or desires influenced by hormones; *Environmental*, vision of food whether face to face or virtual and the smell; *Mental*, which are governed by thoughts or memories about food; *Emotional*, negative or positive emotions associated with the desire to eat, either to supply the negative or to celebrate the positive; *Social*, encouraged from other people eating (BECK, 2009).

Listing realistic objectives of the therapeutic process is primordial, also because they are essential in maintaining motivation. Therefore, it is interesting to write a kind of motivation card, which are the reasons why the patient wants to solve the initial complaint. In another moment, adaptive responses to dissociative thoughts, to the “all or nothing” thought mentioned above, may be required. Example: yesterday I had a lapse, next week I will start the process again from scratch; it can be replaced by: yesterday I had a lapse, which I knew could happen, however, I will continue the process from where I stopped because I already had some learning (BECK, 2009).

Psychoeducation must be part of the process by learning the analysis of cognitive errors, which are groups of what dysfunctional thoughts fit. Whrigh, Basco and Thase (2008, our translation, our emphasis) present some of them:

> *Selective Abstraction*, which can be called ignoring the evidences or mental filter, in order to confirm the person's view of the situation; *Arbitrary Inference*, a conclusion is reached from contradictory evidences or lack of evidences; *Supergeneralization*, the conclusion of an isolated event or of a certain area of the person's life is extended in an illogical way to the other areas of the functioning; *Maximization*, the relevance of an event or attribute is exaggerated or minimized in the case of *Minimization*; *Personalization*, one assumes excessive responsibility or guilt for negative events, while in reality it has no relation to oneself; *Absolutistent Pension*, also called dichotomous or of the type “all or nothing”, in which the judgments about oneself and experiences are either totally good or totally bad, failure or perfection.

Whrigh, Basco and Thase (2008, our translation) defend the Seven Questions Technique:

> 1. What kind of mistake am I making? 2. What is the evidence that this thought is not true (totally or partially)? 3. Is there another way to see the situation? 4. What is the most realistic result for the situation? What effect would believing this thought have on [a friend] if they were in the same situation with the same thoughts? 7. What should i do now? According to these examples of thoughts cited, it is possible to realize that psychoeducation is fundamental to cognitive restructuring, that is, to change thinking in a way that interferes with the unadaptative behavior of the individual.

In addition, learning to plan is fundamental, being able to write the tasks you want to do in a notebook or notebook, in order to follow the written routine can become easier, to behave avoiding the excess of food out of plan or to act following the feeding of previously planned foods. Moments of praise (BECK, 2009) are also valuable as a positive self-assertion, and it is important to elaborate this skill if there is not, since reinforcing thoughts and words are necessary for the patient's own perception of the progress of the process and the growth of its skills.

Game Development

The game Nova Luz is presented in the form of a rectangular board under a theme of train travel and is proposed to be used in therapy sessions mainly in the cognitive behavioral approach and in cases of eating disorders. The game starts in a train station, where as a first step the patient must assemble its character with available body parts, being able to point out which parts bothers it, so it is already possible to find out how it sees itself and has the conception of itself, being able to identify possible distortions; and has as the end the exit of a tunnel that radiates light and the landing of the destination station. The game, although playful, is indicated for teenagers and adults, it aims to treat the theory and teachings in a relaxed way and that the patient's responses are spontaneous, as well as the investigation of the case.

There is a joke with words in the construction of the material, in the title and as the game unfolds, Nova Luz refers to the “light at the end of the tunnel”, that's why the theme railway with passages through tunnels and the train as a means of locomotion, which is responsible for transporting the patient to such situations, questions, teachings and simulations of daily tasks. Investing in the playful theme, Nova Luz has secondary characters known as the genius of the lamp and the monkeys of the 3 senses, in addition to challenges

imposed on the play. The announcer of the game is the conductor, being played by the psychologist in question and the piece used for locomotion is a train car that will also take the answers written by the patient during the game.

The material has moments of analysis of the initial demand and personal motivations. There are moments of psychoeducation such as the explanation of secrecy and professional ethics, the CBT, the cognitive model, cognitive errors, questioning of evidence, unadaptative and adaptive thoughts, in addition to the confection of a confrontation card. To maintain self-esteem, there are moments of teaching what it means tied to the situation in which one finds oneself in the game, enumeration of those of the patient ability and the practice of praising oneself. There are also situations inquiring if in the patient's routine there is presence of diet, physical exercise, multidisciplinary team and personal support.

On the path represented by the train line there are colored circles that correspond to the stops: purple is the first circle guiding that the avatar should be mounted, red when it is simply to answer out loud, blue with the matching number of the letter that should be removed, green with the pencil symbol exposing that it is to write the answer and deposit it in the wagon. The character referring to speech is indicated on each balloon. The yellow stars illustrated along the board are the curiosities in the style such as "Did you know?", in which whenever the patient passes by he must freely choose a star-shaped letter and give it to the psychologist to read aloud, among these curiosities are: the importance of praising oneself; the time it takes to realize that one is really satiated; the difference in hunger, desire and desire to eat; the different stimuli that lead one to eat; the orientations on how to eat consciously; the teaching of breathing; the explanation that the healing process is not linear; and the C.A.L.M.D.O.W.N. technique idealized by Bernad Rangé, defending the idea that the best way to deal with the state of anxiety is by accepting it, for this the technique is divided into 8 steps: Accept your anxiety; Behold things around you; Act with your anxiety; Free the air from your lungs; Keep the previous steps; Examine your thoughts; Smile, you did it; Wait for the future with acceptance (RANGÉ, 2001).

Therefore, this game aims to help in cases related to eating disorders, by addressing the initial complaint and the patient's motivations, dealing with self-esteem, eating awareness and how to deal with behaviors related to anxiety, in addition to explaining how the cognitive behavioral approach works. It can be used early in the therapeutic process to contribute by addressing already mentioned issues related to the eating disorder or later in psychotherapy as a tool for maintenance and analysis of the progress of the case, as well as the ratification of the teachings.

Final considerations

This study sought to expose the context of current food issues, emphasizing the casters, fast food, the abundance and appreciation of food, in return for the enhancement of the perfect lean body evidenced by the media, especially the fruit of social networks. In addition, data were cited showing the decrease in malnutrition and increase in obesity found in the Brazilian population.

Regarding the existing eating disorders, the main topics discussed were eating compulsion, anorexia and bulimia, since these are the most specific ones in the literature, besides the correlation regarding body concern and social pressure. Thus, the history and diagnostic conditions were argued, followed by the revelation of multifactorial factors, since there is a diversity of factors that interact with each other in a complex way to produce, develop and perpetuate the disease, being these compounds of genetic predispositions, socio-cultural and biological and psychological vulnerabilities.

Regarding cognitive-behavioral therapy, a brief history and characterization was presented, this approach being based on the cognitive model and using techniques and behavioral strategies, thus, strategies used by psychotherapists in cases of eating disorders were presented, resulting in the contribution of ideas related to the development of the game.

It was concluded possible the elaboration of the game with the intention of helping in cases related to eating disorders, so that the session becomes less tense and more fluid, in addition to the realization of the idea that although there was the use of the playful resource, that it would be used for psychotherapy with adolescents or adults, therefore, that it would not convert to infantilized material. The option of using it at the very beginning of the therapeutic process can be confirmed, in order to contribute to the treatment of the already mentioned issues related to eating disorders, as well as later in psychotherapy as a tool for maintenance and analysis of the progress of the case, as well as the ratification of the lessons already learned during the game.

Brazil still does not have a large amount of material about eating disorders, so it is understood that it is an area in progress that needs studies. The games, currently used as resources in psychotherapy, in their general way, are directed to childcare. Thus, this study unites two factors still in progress in Brazilian cognitive-behavioral therapy.

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