Anorexia nervosa: a psychological perspective of etiology and current treatment procedures

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Abstract
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ANOREXIA NERVOSA: A PSYCHOLOGICAL PERSPECTIVE OF ETIOLOGY
AND CURRENT TREATMENT PROCEDURES

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Abstract

Anorexia nervosa is a chronic and sometimes fatal illness characterized by physical and psychological complications. Although no etiology for this illness has been determined, this paper presents a psychological etiology based on a synthesis of both traditional and current literature. The influence of culture, the therapeutic alliance, and client resistance are also considered. Relapse is common and the illness may last for many years. The health care community has addressed the complexity and chronicity of this illness by using a multicomponent approach that includes psychoeducation, cognitive-behavioral therapy, psychodynamic interventions, family therapy, and psychopharmacology.
Anorexia Nervosa:
A Psychological Perspective of Etiology
and Current Treatment Procedures

Few psychiatric disorders demand our attention as does anorexia nervosa. The purposeful and compulsive behaviors that lead to self-starvation seem to defy the basic laws of life and survival. The perplexing nature of this often chronic and sometimes fatal disorder has given rise to many suggestions of etiology as clinicians attempt to formulate treatment procedures that reflect its complexity. Anorexia nervosa is a multifaceted illness that requires treatments that are intense, efficient, flexible, and multidisciplinary in order to achieve positive long-term outcomes.

Anorexia nervosa presents with both physical and psychological complications. Current treatment practices are based on an understanding of these complications, along with descriptive and diagnostic criteria of the illness. Presentations of anorexia nervosa that meet full criteria are relatively uncommon (0.5%-1.0%), and the counselor is more likely to treat clients who present with partial syndromes (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, 1994), particularly on college campuses where there is a large population of young women. This opportunity for early detection and treatment is one hope in curtailting the often long term-course of this illness (Andersen, 2000; Hsu, 1990).
Managed care has added another dimension to the process of mental health care delivery and the choice of treatment procedures for anorexia nervosa. Clinicians must practice within the confines of the managed care system, which has placed cost and time limitations on inpatient hospitalization. Although extended hospitalization to restore body weight is still available in some locations, alternative settings such as short-term hospitalization, day treatment programs, partial hospitalization, and outpatient programs must meet both client needs and managed care requirements (Peterson & Mitchell, 1999). Treatment programs must demonstrate to health insurance companies that clients are improving, symptom resolution is occurring, and relapse rates are low (Andersen & Bowers, 1997).

The purpose of this review is to describe anorexia nervosa, present a psychological perspective of etiology, and outline some current treatment procedures. Because anorexia nervosa is predominantly an illness among young European American (white) women, the focus will be on this population.

Description and Characteristics of Anorexia Nervosa

Diagnostic Description

According to the DSM-IV (1994) fourth edition, anorexia nervosa presents as a severe disturbance in eating behavior and as a refusal to maintain a minimally normal body weight for age and height. The disorder is further characterized by an intense fear of weight gain, although the individual is underweight; a distorted
perception of body size and shape; self-evaluation based on body image; the absence of at least three consecutive menstrual cycles; mood disorders, most often depression; and obsessive-compulsive behavior relating to food and exercise.

Anorexic behavior is divided into two subtypes. In the first subtype, weight loss is accomplished by food restriction, dieting, fasting, and/or excessive exercise; and in the second subtype by purging behaviors, including self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Bingeing may be a part of the purge cycle. Both subtypes, the restricting subtype and the binge-eating/purging subtype, are serious. The bulimic subtype is more physically damaging due to the additional stress on the body (Well-Connected, 1999).

The DSM-IV (1994) fourth edition notes that anorexia usually occurs in adolescence with the mean age at 17 years. Epidemiological studies show an increase in the incidence over the past 20 years (Wakeling, 1996). Anorexia nervosa is the third most common chronic illness in adolescent women and is believed to affect 0.5% to 3% of all teenagers. Risk for developing anorexia nervosa is greater in industrialized societies, and a society’s degree of industrialization appears to be a greater determining factor than ethnic group or social class membership (Well-Connected, 1999). The DSM-IV (1994) fourth edition indicates that among those individuals admitted to university hospitals, over 10% die from the effects of starvation, suicide, or electrolyte imbalance. Other
studies place the death rate as high as 18% (Andersen, 2000). Anorexia nervosa has the highest death rate of any psychiatric disorder (Sullivan, 1995).

Physical and Psychological Profile

The most serious consequences of anorexia nervosa stem from self-starvation. The changes caused by starvation occur when the body can no longer make metabolic adjustments to caloric loss. Problems include bradycardia and heart disease, the most common medical cause of death; electrolyte imbalances; reproductive and hormonal abnormalities, including amenorrhea; osteoporosis; lanugo, a fine hair growth on the trunk of the body; and dry yellowish skin. Also, neurological problems including nerve damage, seizures, and structural changes in the brain; blood problems including anemia; and gastrointestinal problems (Andersen, 2000; Garner, 1997; Hsu, 1990; Well-Connected, 1999). Although serious, most complications due to starvation can be reversed (Garner, 1997).

Adolescents who develop anorexia nervosa are described as having high emotional reserve and cognitive inhibition, a desire for routine and predictability, heightened conformity and deference to others, avoidance of risk, excessive rumination, and perfectionism (Strober, 1997). Other characteristics include social introversion; a decrease or loss of interest in sexual activity; and participation in sports, ballet, modeling, wrestling, and other activities that promote thinness and competition (Andersen, 2000).
Family Characteristics

Family characteristics linked to anorexia nervosa include family members with an eating disorder, depression and other affective disorders. Also, poor communication skills, the inability to resolve conflict and tension, an emphasis on propriety and rules, overprotection and discouragement of autonomy, preoccupation with physical appearance, and adults who are overly critical. There is a greater likelihood of alcoholism and substance abuse than found in the general population, and a high incidence of physical and sexual abuse (Strober, 1997; Vanderlinden & Vandereycken, 1997).

Comorbid Psychiatric Disorders

Depression is the most common affective disorder associated with anorexia nervosa. Up to 80% of clients experience depression, which may be the result of the body's starved condition and compromised biochemical state (Hsu, 1990; Well-Connected, 1999). However, depression often improves with weight restoration. Anxiety disorders are also common, including social anxiety, panic disorder, and obsessive-compulsive disorder. Obsessive-compulsive behaviors characterize patterns of eating, calorie counting, and exercise, in the relentless pursuit of thinness (Sargent, 1999).

Several personality disorders are often diagnosed along with anorexia. Dennis and Sansone (1997) note 30% of the restrictor subtype are estimated to be avoidant personalities. Dependent and obsessive-compulsive personality are also
common. In the bulimic subtype, up to 40% are borderline personalities. Anorexia clients are also highly likely to have narcissistic features, including the inability to soothe oneself, to empathize with others, a need for admiration, and hypersensitivity to criticism. The bulimic subtype of anorexia is especially likely to have concomitant substance use disorders, notably with alcohol, street drugs, as well as atypical substances such as laxatives, diuretics, diet pills, and ipecac (Mitchell, Specker, & Edmonson, 1997).

Comorbidity, along with longer duration of illness, extremely low weight, poor family relationships, and a previous history of treatment failure, often indicate a greater likelihood of poor long-term outcome and sometimes death (Herzog et al., 2000; Well-Connected, 1999). Recovery may also be hindered by cultural values that encourage dieting behaviors. Those clients who do recover, between 75% and 90%, may still exhibit binge eating, concern with eating and dieting, and obsessive-compulsive behaviors. Recovery refers to weight restoration and more normal social functioning rather than to cure.

The Importance of Etiology in Treating Anorexia Nervosa

Culture with its emphasis on dieting and thinness is often implicated in the development of anorexia nervosa (Hsu, 1990). Culture, however, only provides distractions from problems, distractions such as dieting, gambling, or substance use are employed to meet psychological needs (May, 1977). Anorexia nervosa has a
purpose that is more than just altering weight, and this purpose becomes clearer when etiology is considered.

The disturbing image of the client with anorexia nervosa, often dreadfully underweight as a result of food restriction or purging, possibly struggling with psychiatric complications, pleads for an answer to the following questions. What causes this illness? What purposes do these symptoms serve? Also, can there be successful treatment without attention to etiology? The answers to these questions require an understanding of what motivates human behavior. Theory is derived from an understanding of human behavior, and treatment procedures are an outcome of theory. Insight into human behavior, may therefore provide the best hope for effective treatment procedures and long-term positive outcomes.

The Need to Belong

Although the symptoms of anorexia generally present during adolescence, the roots of this disorder are found in childhood (Andersen & Bowers, 1997). A psychological perspective of etiology takes into account human needs and behavior. The need to belong is the primary human motivation (Dreikurs, 1960). The need to belong is expressed in current literature as connection and attachment (Garbarino, 1999). When the human need for belonging or connection is met, security, safety, and ultimately survival are possible. Belonging is a quality of social/familial units in which all aspects of interpersonal union, love, and intimacy are learned (Fromm, 1956).
Culture and environment, family and genetics influence how well needs are met, but the need for belonging is changeless and enduring. The degree to which this need is met and integrated with societal demands determines psychosocial growth. When the needs of infancy and childhood are met, favorable conditions exist for the development of those personality traits that make the tasks of adolescence and adulthood more manageable (Erikson, 1963). When needs are satisfied, trust, hope, the ability to love and have faith in self and others develop. This is reflected in a belief system that is basically optimistic and hopeful. When the needs for belonging, safety, and security are frustrated, an anxious orientation to the world develops (May, 1977), as well as a belief system that perpetuates the anxiety (Beck & Emery, 1985). Thus, beliefs and assumptions about self and others are products of the psychosocial context in which each person strives to get the need for belonging met. These early beliefs eventually become the schemas or cognitive patterns that determine how the individual responds emotionally and behaviorally to internal and external stimuli. When the basic need for belonging is not met, anxiety is the usual response.

Anxiety and Anorexia

Anxiety is a primal response to danger that threatens the core or essence of the person (May, 1997). The individual endeavors to resolve the discomfort, the pervasive vulnerability, and the lack of control that anxiety evokes, as well as to prevent its recurrence (Beck & Emery, 1985; May, 1977). When the individual is
unable to alleviate the anxiety, that is fight or flight, and is in danger of being overwhelmed by the anxiety, she will develop behaviors to ease the anxiety (May, 1977). These compensatory and sometimes pathological behaviors have the singular purpose of allowing the individual to cope with difficult, unfriendly, or threatening environments, and anorexia nervosa is one such pathological syndrome. “By starving herself, she [the anorexic] feels strengthened and temporarily superior to others. This is the antidote to her feelings of weakness, shame, and inadequacy related to her true need of others” (Goodsitt, 1997, p. 210). Anorexia nervosa, therefore, is both a friend and a foe (Andersen & Bowers, 1997). As a friend, it replaces unmet needs and eases anxiety. As a foe, it severely narrows psychological focus, leading to further isolation (Nakken, 1996), and causes grave physical consequences. Seemingly dysfunctional obsessive-compulsive rituals with eating and food give the illusion of security, the feeling that one is not alone, that “someone is home” (Roth, 1991, p. 18).

The association between anxiety and anorexia nervosa is supported empirically. In a controlled study (Bulik, Sullivan, Fear, & Joyce, 1997), the plausibility of antecedent anxiety disorders being risk factors for anorexia nervosa was supported. In the anorexia group (n=68), 90% reported anxiety symptoms predated anorexia, with obsessive-compulsive disorder, overanxious disorder, and separation anxiety disorder noted most often.
Addiction and Anorexia

Unmet needs for belonging, connection, and intimacy result in anxiety and alienation. This is considered the basis for addiction (Fromm, 1956; Nakken, 1996). Both addiction and anorexia nervosa share certain compensatory and pathological aspects. Addiction can be defined as an overinvolvement with or a pathological relationship with an object or event (Nakken, 1996). The purpose of this relationship is to produce a desired mood change or trance-like state to ease discomfort and to escape from separateness (Fromm, 1956). According to Nakken, addictive behaviors and rituals take the place of human relationships. They become the primary emotional relationship leading to psychological dependence and physical deterioration.

Addiction provides consistency and security; it involves thinking, feeling, and behaving and thus the total personality. This total involvement is accomplished through ritualistic behaviors and mental preoccupation, which in turn stops emotional distress and pain (Nakken, 1996; Sargent, 1999). "Starving myself or bingeing had been my way of effectively blocking out feelings. Emotionally, I was as numb as an alcoholic who passes out after one drink too many" (Sargent, 1999, p. 103). Eating disorders act like alcohol and drugs by distracting the person from negative feelings and experiences. And like addictions, these behaviors become a problem all their own, leaving important issues unresolved (Garner, Vitousek, & Pike, 1997).
Abuse, Trauma, and Anorexia

Such unresolved issues may include a history of physical abuse, sexual abuse, or other trauma. Research has not conclusively shown that early abuse is a specific risk in developing eating disorders; however, there does appear to be a link between early trauma and subsequent pathological eating patterns, especially bulimia nervosa and the bulimic subtype of anorexia nervosa (Fallon & Wonderlich, 1997). Abuse and trauma increase the risk for developing a constellation of psychiatric disorders that often present along with anorexia nervosa, particularly the bulimic subtype. These disorders include depression, anxiety, substance use and addiction, borderline personality disorder, and dissociative symptoms. Pierre Janet, 19th century philosopher and psychiatrist (as cited in Vanderlinden & Vandereycken, 1997), coined the phrase “mental avoidance” to describe escape from physical and emotional pain. Mental avoidance, currently referred to as dissociation, functions as a coping or survival mechanism in the face of overwhelming threat. Bulimic behaviors may function in much the same way to numb awareness or even induce a kind of freezing state that allows avoidance of painful memories or management of triggers that evoke similar emotions (Vanderlinden & Vandereycken, 1997).

Although the causes of anorexia nervosa cannot be stated with certainty, it seems likely that a person’s beliefs, intense emotional states such as anxiety, psychosocial context, and personal history influence the development and course
of this illness. And although each person is a unique product of biopsychosocial forces, people also have in common needs that are basic to human nature, such as the need for belonging. The fulfillment of these needs influence mental health. The best hope for recovery from anorexia nervosa, therefore, requires attention to the past and early experiences. Unless the origins of beliefs and behaviors are addressed, change will be superficial and relapse is likely to occur (Fallon & Wonderlich, 1997).

A Multicomponent Approach for Treating Anorexia Nervosa

Anorexia nervosa is biopsychosocial in nature, involving physical health and mental status, comorbid psychiatric disorders, client motivation for change, and relapse prevention. Family involvement, financial considerations, age of the client, as well as choice of treatment setting are also taken into account. Effective treatment plans must take into consideration the breadth and depth of this illness.

Many treatment programs use a cognitive-behavioral foundation along with psychoeducation and psychodynamic interventions as additional components (Andersen & Bowers, 1997). The client is usually engaged in individual, group, and sometimes family therapy. Relapse prevention and aftercare are also considered. Implementing the multicomponent treatment plan is the responsibility of a treatment team that works together and individually to help the client move along a sometimes arduous path toward recovery. For some clients, this path may
involve several hospitalizations and a history of relapse (Sargent, 1999) also described as recycling through the change process (Prochaska, DiClemente, & Norcross, 1992). The first step in this process of change is the engagement of the client in the therapeutic process. This important task falls upon the counselor or therapist.

The Therapeutic Relationship

The therapeutic relationship is at the heart of successful counseling outcomes, and is considered a cornerstone in the process of change (Prochaska et al., 1992). Establishing a positive therapeutic alliance is important in mitigating client fears, overcoming resistance, and enhancing motivation. Working with a client who has anorexia nervosa poses special challenges that include client resistance that could influence the clinician’s decision to forego or limit treatment, as well as ethical considerations regarding client welfare.

Client engagement depends in part on the qualities the counselor brings to the therapeutic relationship. These qualities include warmth, accurate empathy, genuineness, trust, and an understanding of when to be direct (Garner et al., 1997). The counselor must be a caring professional who is encouraging, able to share expert knowledge and educate the client, a model in delaying gratification and using good judgment, able to provide a safe therapeutic environment, and a carrier of hope. Within this empathic connection, the client learns she counts, is important, and worthwhile (Goodsitt, 1997).
Overcoming resistance and cultivating and sustaining motivation for change are key factors in the initial phase of treatment (Garner et al., 1997). Client resistance results from the fear of losing the anorexic identity or the security of the anorexic relationship, both of which serve as compensatory or survival mechanisms. Previous hospitalizations may have left the client wary and distrustful toward mental health professionals (Sargent, 1999).

**Strategies and Interventions.** Bibliotherapy or the suggestion to join a support group may be offered to the resistant client (Hsu, 1990). A letter to the client and/or family before the first session may help to allay fears. The letter could request the client prepare an autobiography and provide pertinent information about her illness. Such a request communicates therapist commitment and sincerity to the client (Strober, 1997). The client could be assisted in developing a detailed list of the advantages and disadvantages of anorexia and how it helps solve her problems. The purpose of this request is to introduce doubt about how well anorexia works for the client (Garner et al., 1997).

The aim of all of these exercises is to move resistant clients from a precontemplation stage in the process of change to a contemplation stage in which they gain an awareness of their illness (Prochaska et al., 1992). To avoid feelings of discouragement and disappointment for both client and therapist, it is important to match treatment goals and procedures with client stage of readiness (Prochaska et al., 1992).
Client engagement, while critical, is not always possible. Resistant clients may not go beyond the first session, but are invited to make contact at a later time (Hsu, 1990) and can be assisted in coping with symptoms (Garner et al., 1997). The adult client with a long history of illness, who is socially and sexually withdrawn, is a poor risk for treatment. In these instances, management of the illness rather than treatment is a preferable alternative (Strober, 1997).

Involuntary Clients and Ethics. Therapists may also find they must make critical decisions when client welfare is at risk. It may be necessary to treat an involuntary client when the severity of symptoms warrants such action (Goldner, Birmingham, & Smye, 1997; Hsu, 1990). However, force or restraint can intensify a client’s sense of isolation and loss of control (Sargent, 1999) and may lead to negative emotional consequences for treatment staff as well (Goldner et al., 1997). Yet, involuntary treatment can also be lifesaving, and clinicians may find they must make these critical ethical decisions and weigh the responsibility of doing no harm against the responsibility of doing what is in the best interests of the client (Goldner et al., 1997).

Some recommendations for the clinician include the following: (a) evaluate the client’s physical condition and risks, (b) know the likely benefit and likely harm of treatment, (c) evaluate the mental competence of the client to make a reasonable decision, (d) utilize both medical and legal expertise, and (e) use clinical decision analysis, i.e. decision-making tree, to assist in the decision making process.
(Goldner et al., 1997). The therapist may need to break confidentiality when treating severely ill clients who are away from home and refusing treatment. In this case colleagues should be consulted, and the client should be informed of the intent and reasons to contact family, which should be done in the client’s presence. All actions taken should be documented in the client’s case record (Hsu, 1990).

Client engagement is an ongoing process whereby the therapist provides encouragement, support, and confrontation when necessary as the client moves through the various phases of treatment. The initial step in treatment for the client is to reach a body weight that removes the risk of physical and psychological complications. This is usually achieved through psychoeducation.

Psychoeducation in the Treatment of Anorexia Nervosa

Weight stabilization is considered a prerequisite for psychotherapy (Garner, 1997). The treatment of a starved and emaciated client has been likened to treating an intoxicated client (Garner et al., 1997). Psychoeducation regarding the consequences of starvation is a consciousness-raising effort intended to increase client awareness through education, bibliotherapy, and discussion, as well as to enlist client cooperation in the treatment process (Prochaska et al., 1992).

Resistance to weight restoration may be overcome by assuring clients they will not be allowed to become overweight; seeking agreement from clients to maintain a minimum weight or weight range, thereby giving them control; and redefining food as a medication to restore health and energy. Also, using weight
 restoration as an experiment whereby clients can determine if they are truly in control of their weight, or placing weight restoration within the context of achieving personal goals (Andersen & Bowers, 1997; Garner, 1997; Garner et al., 1997; Vanderlinden & Vandereycken, 1997).

Restoring regular eating patterns is achieved through a structured program of mechanical eating, or eating at set times to prevent food cravings; spacing meals, also intended to reduce cravings and undereating or overeating; and self-monitoring, or the daily recording of all food and liquid consumption as well as the occurrence of weight-controlling behaviors. Structure in treatment may allow clients to relax rigid rules about food (Garner, 1997).

Although weight restoration and nutritional rehabilitation are important first steps in the recovery or change process, weight restoration alone is a poor predictor of long-term outcome (Hsu, 1990). The central task of treatment is to help clients not only act differently, but to think differently about food and their body, and come to an understanding of the role anorexia nervosa has come to play in their lives (Andersen, 2000).

Cognitive-Behavioral Treatment

Addressing and restructuring the client's belief system is the hallmark of cognitive-behavioral therapy (CBT), the work of Aaron Beck and his colleagues which has been incorporated into eating disorder programs (Garner et al., 1997). CBT principles emphasize present functioning, conscious thinking, and behaviors
that are observed or described by the client as causing and maintaining the illness. This therapy is characterized by the use of questioning as a major therapeutic tool, an active and direct role for the therapist, and work outside the session to further explore beliefs and thinking patterns (Garner et al., 1997). From a CBT perspective, anorexia nervosa results from rigid or extreme schemas, or cognitive patterns, which lead to dysfunctional behavior, misinterpretation of experiences, and extreme and/or negative thinking. “The eating-disordered belief system is based on lies that keep an individual stuck in the illness cycle. To recover, I needed to change and refute those faulty beliefs” (Sargent, 1999, p. 140). As cognitions are modified, so too will harmful behaviors and distressing feelings change (Garner et al., 1997). An important goal of treatment therefore is the discovery and modification of distorted cognitions regarding weight, body shape and image, the fear of fatness, and the pursuit of thinness (Andersen & Bowers, 1997).

Garner et al. (1997), note common errors in reasoning or thinking that might be encountered:

1. Selective abstraction: basing a conclusion on a few details while ignoring other pertinent evidence, i.e., “The only way I can be in control is through eating.”
2. Overgeneralization: taking an interpretation based on one event and applying it to other situations, i.e., “When I was normal weight, I was not happy, so gaining weight will not make me happy.”

3. Magnification: overestimating the significance of an event not supported by objective evidence, i.e., “Gaining five pounds would push me over the brink.”

4. Dichotomous, or all-or-nothing thinking: thinking in absolute or extreme terms, i.e., “If I gain one pound, I might as well gain a hundred pounds.”

5. Personalization: interpreting impersonal events egocentrically, i.e., “When people laugh or whisper, I know it is about me.”

6. Superstitious thinking: believing in the cause-effect relationships of nonrelated events, i.e., “If I am happy, something terrible will happen.”

Once negative beliefs have been identified, they can be challenged and replaced with positive beliefs. The following techniques are used to change these patterns of thinking:

1. Decentering: appraising the client’s egocentric beliefs from a more objective viewpoint.


3. Decatastrophizing: clarifying, challenging, and diffusing feared outcomes and scenarios.
4. Highlighting the dissonance between beliefs and behaviors: helping dismantle behaviors maintained by habit.

5. Reattribution techniques: attributing body size misperceptions to the illness rather than to reality, i.e. "Because anorexia make me feel fat, I must use a scale to get an accurate reading of my size."

6. Creating dissonance between incompatible schema: using weight or body perception to evaluate the worth of someone other than the client, so that it loses its strength and validity.

7. Challenging beliefs through behavior exercises: engaging in social interaction to lessen the view of self as socially incompetent (Garner et al., 1997).

8. Self-talk: identifying erroneous messages and replacing them with constructive messages (Beck & Emery, 1985).

9. Clients who have experienced a history of trauma or abuse benefit from having their mind distracted and their distressing feelings calmed through guided imagery, relaxation techniques, walking, meditating, using a diary to express feelings and thoughts, and reaching out to others (Fallon & Wonderlich, 1997; Vanderlinden & Vandereycken, 1997).

The purpose of cognitive restructuring is to replace harmful and nonproductive thinking with productive thinking. Although CBT does not focus on the client's personal history, the therapist cannot ignore the origins and reasons for clients' beliefs when leading them through cognitive restructuring. Otherwise
clients may conclude they are irrational for feeling and thinking as they do (Fallon & Wonderlich, 1997). Because beliefs do not develop in a vacuum but are the outcome of the interaction between the individual and the environment, therapists cannot ignore the origins of the belief system lest they build on a foundation of sand. For these reasons, a psychodynamic component is generally incorporated into treatment.

The Psychodynamic Component of Treatment

The purpose of a psychodynamic component is to uncover and relate the client’s history to the development of anorexic behaviors. The focus is on identifying the legitimate and previously unmet need for human connection that is vital to psychological health and well-being (Goodsitt, 1997). Techniques employed by the therapist may come from various models of psychodynamic theory. The success of these techniques rests on a therapeutic alliance in which the client feels understood and validated. The goal is for the client to tell her story. Attention is given to the client’s inner world of feelings, especially feelings of emptiness, fear of personal needs, sense of ineffectiveness, loneliness, and low self-esteem. As Sargent (1999) indicated, “An eating disorder is not really about extreme weight loss or gain. It’s about how one feels about oneself. A good therapist will work with a person to enhance self-esteem, assertiveness, and feelings of self-worth” (p. 149).
The therapist might focus on interpersonal relationships as the means for revealing client strengths and weaknesses. Specific themes might include the client as family caretaker, the need for approval, fear of rejection, excessive dependence or lack of assertiveness, sexual conflict or trauma, grief issues, and caretakers who could not meet the developmental needs of the child. By reviewing historical relationships, the meaning of current patterns of interaction becomes clear (Garner et al., 1997). Experiential techniques are useful in encouraging emotional expression. Discussion can be centered around a family photograph to reveal how family members related, how they cared for or hurt the client. Drawings of the family or home may be used in the same way. Clients who are trauma survivors may need to tell their story many times. They may write their story, read their story to a group, or reenact parts of the story, with each method allowing the client to connect to the past on several levels (Fallon & Wonderlich, 1997). The awareness that comes from connecting the present to the past increases the chance for long-term recovery.

Family Therapy as a Component of Treatment

Ethical, financial, and practical reasons for involving the family exist, especially for young clients (Garner et al., 1997). For clients under 18 years, treatment success depends upon including the family in the treatment process (Andersen, 2000). It is important that family members understand fully the implications of the disorder as it relates to the client's well-being (Well-Connected,
Family members have needs and concerns that must be addressed, especially if the client will be returning to the home environment. Parents and siblings may have feelings of guilt, anxiety, frustration, and grief that are both the result and cause of anorexic behaviors. Parents might be suffering from physical or psychological illnesses that require therapeutic intervention (Goodsitt, 1997).

Regardless of theoretical orientation, the goal is to encourage a family environment conducive to the psychological health of its members. In general, family therapy endeavors to facilitate family functioning and communication, to bring about appropriate levels of togetherness and separation, and to assist family members in making age-appropriate decisions (Andersen & Bowers, 1997). Special problems that may be encountered include parents who are divorced or separated, a parent who has physically or sexually abused the client, or highly negative family interactions. In these instances, the therapist must protect the client from further physical or emotional harm (Vanderlinden & Vandreypecken, 1997). If necessary, alternative living arrangements may help the client achieve autonomy and independence. It is also important for the therapist to appreciate the frustration of parents, acknowledge their fears, and understand when they become disdainful and question treatment. "I was told on at least three different occasions... Judy was hopeless, that she was schizophrenic, that she belonged in the state hospital... I knew that if I chose to believe the doctors, Judy would give
up and die” (Sargent, 1999, p. 167). Thus, psychotherapy includes not only the client and treatment team, but often the family as well.

The Pharmacological Component of Treatment

Along with psychotherapy, medication may be used as an adjunct therapy for comorbid disorders and as an aid to restore and maintain normal body weight. Drug therapy has been helpful in the treatment of several disorders that are often comorbid with anorexia nervosa such as depression, anxiety, and obsessive-compulsive disorders (Mayer & Walsh, 1998).

Attention has focused on the use of selective serotonin reuptake inhibitors (SSRIs), particularly fluoxetine (brand name Prozac). Overall, research has suggested that the impact of fluoxetine on client improvement has been disappointing (Attia, Haiman, Walsh, & Flater, 1998; Mayer & Walsh, 1998). The effectiveness of SSRIs may be compromised in malnourished and underweight clients (Kaye, Gendall, & Strober, 1998). Antidepressants are more likely to be effective after weight restoration and normalization of eating patterns have occurred and when there is evidence of continued depression, anxiety, or obsessive-compulsive behaviors (Andersen & Bowers, 1997; Mayer & Walsh, 1998). The use of medication to enhance appetite is not encouraged because without the benefits of change based on psychotherapy, improvement is usually short-term (Andersen & Bowers, 1997). Research continues in the drug treatment
of anorexia nervosa, especially as a method of maintaining the gains made during hospitalization and in preventing relapse.

**Relapse Prevention as a Component of Treatment**

Because relapse is not uncommon in anorexia nervosa (Hsu, 1990), relapse prevention is an important goal of treatment (Andersen & Bowers, 1997). If the client has been hospitalized, a program of aftercare, including partial hospitalization or outpatient treatment, may follow for one year or longer. Relapse or recycling has been described as part of the natural recovery process as clients attempt to modify or stop addictive-type behaviors (Prochaska et al., 1992). Relapse after discharge is more likely when weight remains low, severe distortion of body image continues, and purging and the drive for thinness continue. Relapse is also more common when comorbid psychiatric problems remain unresolved, the client returns to a dysfunctional environment, and no follow-up facilities exist (Andersen & Bowers, 1997). Stress, the death of a family member or friend, marital and family problems, the reactions of other people, and the fear of living without anorexia nervosa may also trigger relapse (Relapse Prevention Plan, 1999).

Clients are encouraged to view relapse as a slip in the recovery process, to avoid perfectionistic or all-or-nothing thinking, and to practice the “four R’s”: (a) reframe the episode as a slip and not as a failure, (b) renew the commitment to long-term recovery, (c) return to regular eating patterns, and (d) reinstate
behavioral controls to halt future episodes, such as contacting a friend, relaxation exercises, etc. (Garner et al., 1997). Relapse may signal the need for readmission to a hospital setting. The client's weight, and a return or worsening of medical or psychiatric complications are reasons for readmission (Andersen & Bowers, 1997).

Conclusion

The selected topics covered in this review present anorexia nervosa as an illness with both breadth and depth. The disorder includes physical and psychological complications, is in some way exacerbated by contemporary culture, and requires the expertise of health professionals from a variety of disciplines. Anorexia nervosa, the roots of which may be found in early psychosocial development, governs all facets of the client's life. The client is often resistant to treatment, thus adding to the challenge faced by the helping professional. These factors have influenced the efforts and practices of current treatment programs.

Changes in the health care system, especially the trend toward shorter hospitalization and outpatient care, have motivated health care professionals to develop new and more efficient treatment options. Current treatment procedures include psychoeducation, cognitive-behavioral, and psychodynamic components; in addition, family therapy is often included. Research to develop effective drug therapy continues. This multicomponent approach attempts to treat all aspects of anorexia nervosa, and to help the client find a sense of wholeness, well-being, and connection.
References


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