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Effectiveness of cognitive-behavioral therapy for anorexia nervosa

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Abstract

Today in the United States, we have become a society so worshipful of bodily thinness that millions suffer to attain 2 it - some even to the point of death. How did we get this way? Fear of obesity appears to be deeply ingrained in our society as a result of the cultural preoccupation with obesity and the value placed on being slim (Herzog, Keller, Strober, Yeh, & Pai, 1992). Television and magazines promote the goal of thinness with regard to both beauty and health. Love, happiness, admiration and wealth are closely identified with a slender form (Clark, Feldman, & Channon, 1989).

Effectiveness of Cognitive-Behavioral Therapy For Anorexia Nervosa

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Today in the United States, we have become a society so worshipful of bodily thinness that millions suffer to attain it - some even to the point of death. How did we get this way? Fear of obesity appears to be deeply ingrained in our society as a result of the cultural preoccupation with obesity and the value placed on being slim (Herzog, Keller, Strober, Yeh, & Pai, 1992). Television and magazines promote the goal of thinness with regard to both beauty and health. Love, happiness, admiration and wealth are closely identified with a slender form (Clark, Feldman, & Channon, 1989).

Although estimates of the prevalence of anorexia nervosa suggest that it is an extremely rare disorder (Bemis, 1978), more current research contradicts this suggestion (Button & Whitehouse, 1981; Schappi, 1985). Precise statistics are not obtainable because of inconsistent criteria used in various studies and because of indaequate records, but existing studies have put the lifetime prevalence of eating disorders in representative populations between 0.5 and 2.1 percent of the total U.S. population (Crisp, Palmer, & Kalucy, 1976; Pope, Hudson, Yurgelun-Todd, & Hudson, 1989).

Anorexia nervosa occurs primarily in adolescent or young adult females, with male incidence estimated at 5 to 15% of the general population (Bemis, 1978; Garfinkel & Kaplan 1896; Hsu, 1980). In a survey conducted by Kagan & Squires (1984) of more than 2,000 high school students, 20 percent indicated that they overate at least once a week to the extent that their stomachs hurt, 20 percent felt completely out of control over

food at least once a week, and 11 percent of the girls reported that they ate in response to emotional distress. Clearly, this disorder is of great public health concern both because of the frequency and because of the seriousness of the condition.

For a variety of reasons, mental health professionals may choose to be involved in educating society, especially young people, about the dangers of eating disorders. First, anorexia nervosa can cause harmful and potentially life-threatening medical complications (Garfinkel & Kaplan, 1986; Herzog & Copeland, 1985; Kagan & Squires, 1984). Second, while the criteria of human beauty have varied over time and place, society has never, until recent times, assigned the highest aesthetic value to thinness, and then idolized that shape as a goal for the masses (Wardle & Foley, 1989). Last, studies in the U.S. have indicated that the incidence of anorexia nervosa has doubled over the past two decades (Herzog & Copeland, 1985; Kagan & Squires, 1984; Thompson, 1986).

In addition to educating society about anorexia nervosa, mental health professionals continue to search for effective treatments (Bemis, 1978; Herzog & Copeland, 1985; Herzog et al., 1992, Yellowlees, 1988). As is true of any disorder that is difficult to treat and whose etiology is uncertain, a multiplicity of therapeutic approaches have been attempted including drug therapy, group therapy, individual psychotherapy, family therapy, psychodynamic approaches, cognitive-behavioral therapy and medical approaches (Bruch, 1982; Crisp, 1983; Dally, 1981; Kalucy, 1978; Minuchin, Rossman, & Baker, 1978; Neuman

& Halvorson, 1983). Cognitive-behavioral therapy seems to show considerable promise as an effective treatment for anorexia nervosa (Herzop et a., 1992).

The purpose of this paper will be to examine the effectiveness of the cognitive-behavioral approach to the treatment of anorexia nervosa. Secondary focus areas that will be addressed in this paper include clinical features, outcome variables, and suggestions for future research.

Definition and Description

The self-starvation, body emaciation, and other physical and behavioral characteristics noted primarily among female adolescents, were classified by the term anorexia nervosa in the late 1880's by the English physician Sir William Gull (Ollendick & Hersen, 1989). However, this disorder was vividly described as "nervosa phthisis" by Richard Morton as early as 1694 (cited in Bliss & Branch, 1960) when he depicted a case of an 18-year-old girl:

> She was wont by her studying at Night, and continued pouring upon Books, to expose herself both Day and Night to the injuries of the Air, which was at that time cold... I do not remember that I did ever in all my Practice see One, that was conversant with the Living, so much wasted with the greatest degree of a Consumption (like a Skeleton only clad with skin); yet there was no Fever, but on the contrary a coldness of the whole body... Only her Appetite was diminished, and her Digestion uneasie. (pp. 10-11)

The fundamental features of anorexia nervosa have remained

unmodified over the years since Morton's description in 1694, although societal and family patterns have clearly changed since then.

The term anorexia nervosa, literally translated by Richard Morton in 1694, (cited in Bliss & Branch, 1960) means a nervous loss of appetite, and it was commonly believed that anorexics did not experience sensations of hunger. However, clinical and research evidence indicates that this term is a misnomer, and that anorexics do indeed suffer from pangs of hunger (Garfinkel, 1974), often extremely intense.

The Diagnostic and Statistical Manual of Mental Disorders IV (APA, 1994) criteria for the diagnosis of anorexia nervosa as a clinical disorder include the following:

> refusal to maintain body weight at or above a minimally normal weight for age and height...intense fear of gaining or becoming fat, even though underweight...disturbance in the way in which one's body weight or shape is experienced...in females, absence of at least three consecutive menstrual cycles (p. 251).

The refusal to maintain body weight over a minimal normal weight is a central feature of all classification systems for this disorder.

Patients pursue weight loss mainly in one of two ways: by restriction of caloric intake (restrictive anorexia nervosa) or by severe restriction of food alternating with periods of binge eating that terminate in self-induced vomiting or in the use of laxatives and diuretics (bulimic anorexia nervosa) (Herzog

& Copeland, 1985; Hsu, 1980). Clinical descriptions of the behavioral characteristics of persons having both subtypes of anorexia nervosa before the onset of their severe weight loss include obsessive- compulsive characteristics, shyness, conscientiousness and achievement orientation (Bemis 1978; Ollendick & Hersen, 1989). Sexual concerns also seem important in the psychopathology of anorexia nervosa (Leon, Lucas, Colligan, & Ferdinande, 1985).

Restricter anorexics willfully starve themselves to a point at least 15 percent below their ideal body weight (Halmi, Golberg, Eckert, Casper, & Davis, 1979). Even when skeletal in appearance, such patients claim to be overweight (Bruch, 1978; Garfinkel & Garner, 1982). As Bruch (1978) noted, anorexics "vigorously defend their often gruesome emaciation as not being too thin...they identify with the skeleton-like appearance, actively maintain it, and deny its abnormality" (p. 209). The inability to objectively assess one's physical condition is characteristic of persons having this disorder. Restricter anorexics are often more introverted than bulimic anorexics and tend to deny that they suffer hunger and psychological distress at any level (Sue, Sue, & Sue, 1990).

In contrast, the bulimic anorexic intersperses severe dieting with occasional binge episodes, followed by vomiting or other means of purgation, such as laxatives (Halmi et al., 1979; Neuman & Halverson, 1983; Ollendick & Hersen, 1989). Bulimic anorexics may also exercise endless hours a day (Kagan & Squires, 1984). They are generally of a higher premorbid

weight level than restricter anorexics, are more extroverted; report more anxiety, depression, and guilt; admit more frequently to having a strong appetite; and tend to be older (Garfinkel& Kaplan, 1986; Hsu, 1980; Sue, Sue, & Sue, 1990).

Distorted attitudes about weight, food, and the body have been consistently recognized as characteristics of persons having anorexia nervosa (Garner, 1986; Yager, Landerverk & Edelstein, 1987). Moreover, it has frequently been observed that maladaptive thinking by anorexics extends beyond food and weight to other areas of experience (Eckert, 1985; Halmi, Casper, Eckert, Goldberg, & Davis, 1979). According to Thompson (1986) women overestimate the size of their waists, thighs, and hips to a much greater extent than do men. They see themselves as being heavier than they are and have as an ideal body image a picture of a much thinner woman. A study of more than 2,000 women found that they wanted to weigh about 9 pounds less than their current weight (Drewnowski, Yee, & Krahn, 1988). Most men seem to equate their current body shape with their ideal shape (Fallon & Roxin, 1985).

Although preoccupation with weight and evidence of a distorted bodily image frequently appear in women in the general population, other factors must be involved, because only a small percentage of individuals actually develop eating disorders. Females with eating disorders appear to suffer from poor self-esteem (Mallick, Whipple, & Huerta, 1987). Bulimics and repeating dieters also believe that they have little control over environmental factors (Dyken & Gerrard, 1986). Immaturity,

passive-aggressiveness, and a self-defeating behavior pattern are found in patients with anorexia nervosa and with bulimia nervosa (Fallon& Roxin, 1985). Scott & Barroffio (1986) found that these patients tend to displace their emotional conflicts onto somatic concerns.

Weight loss allows anorexics to exert control over some area of their lives and may be used as a means of controlling others (Barker & Webb, 1987; Bruch, 1978; Garner, Olmstead, Poliby, & Garfinkel, 1984). One recovered anorexic, whose weight had gone down to 70 pounds, commented, "It's such a manipulative disease...You get people wrapped around your little finger. Any time I wanted my father to visit me in the hospital, I knew he'd be there in a second" (Seligman, Zabarsky, Witherspoon, Rotenberk, & Schmidt, 1983, p. 59).

Cognitive-Behavioral Treatment of Anorexia Nervosa

The treatment of persons suffering from anorexia nervosa and bulimia is one of the most difficult in clinical medicine (Brouwers, 1990). Anorectic patients and their families tend to deny the illness, particulary its severity, and to evade adequate medical and psychiatric care. Furthermore, they often engender negative reactions on the part of medical personnel (Brotman, Stern & Herzog, 1984).

The cognitive approach to understanding anorexia nervosa is based on the concept that the disorder represents a set of dysfunctional behaviors that occur as a result of a difficulty coping with disturbed feelings and thoughts (Brouwers, 1990; Fairburn, 1985; Hsu, Santhouse, & Chesler, 1991). Behavioral

therapy is designed to help the patient gain control of unhealthy eating behaviors and to alter the distorted and rigid thinking that perpetuates the syndrome (Fairburn, 1981). The anorexic behavior is conceptualized as the result of the starved body rebelling and demanding to be fed (Russell, 1979). Cognitive therapy, combined with behavioral treatment, can help clients gain insight into the dynamics of their disorder, improve their self-esteem and sense of control and contribute to the development of better eating habits (Brouwers, 1990; Fairburn, 1981; Kaplan & Sadock, 1985).

According to Brouwers (1990), the goals of cognitive work with anorectics are two-fold. The first goal involves helping the client work toward acceptance of his or her own body. The second goal is to replace the client's emphasis on appearance with an emphasis on function. For example, the client must learn to value functional aspects of his or her body such as walking, talking, laughing, and yes, eating. Judgmental words focusing on appearance, such as fat, thin, ugly, can be replaced with words such as healthy, fit, strong.

Other cognitive areas of concern involve thought process in the form of cognitive distortions such as dichotomous thinking, perfectionistic thinking, overgeneralization and egocentricity (Beck, 1976; Muuss, 1986; Schuyler, 1991). For example, the client may perceive her or his appearance as being either fat or thin, with no middle ground. This dichotomous thinking tends to be pervasive in the lives of anorexics and should be addressed in the larger context of treatment for

anorexia nervosa (Brouwers, 1990; Stone, 1980).

Perfectionistic thinking, overgeneralization, and egocentricity are pervasive in the anoretic's psyche. Perfectionistic thinking may be expressed in body image issues quite clearly in the "I must have a perfect body" attitude (Muuss, 1986; Hoffman, 1984). Overgeneralization can be identified in thought processes such as "my brother said I need to lose weight; therefore, I'm fat and ugly" (Beck, 1976; Freeman & Dattilio, 1992; McMullin, 1986). Egocentricity is evidenced by thoughts such as "everyone is always looking at me and judging my body" (Brouwers, 1990; Hoffman, 1984; Schuyler, 1991).

The behavioral component of treatment for body image dissatisfaction is designed to help the client develop a positive, nurturing attitude toward her or his own body that is expressed behaviorally (Brouwers, 1990; Ellis & Bernard, 1985). Encouraging the client to change some habits may help her or him become more accepting of her or his body (Johnson, & Holloway, 1988). Kano (1985) offered suggestions to people with body image issues: (a) wear loose and comfortable clothing; (b) focus on how one feels rather than how one looks; (c) while exercising, focus on enjoyment, coordination, and endurance rather than on calories burned or desired changes in appearance; and (d) choose physical pleasure and avoid physical discomfort whenever possible.

In addition, the eating disorder client may be encouraged to do things for her or his body, such as get a professional massage, taking a bubble bath, changing her or his hairstyle,

or wearing perfume (Brouwers, 1990; Kano, 1985; Ellis & Bernard, 1985)). Deliberately pampering herself or himself is a step toward treating her or his body with respect and kindness.

Developing Motivation for Treatment

The first step in the treatment of anorexia nervosa is to motivate the patient to gain weight and to discontinue dangerous weight-control practices (Channon, Silva, Hemsley, & Perkins, 1989). During the initial phase of therapy there must be a gradual evolution of trust and openness. Rather than focusing exclusively on weight, the goal is to understand the emotional distress that has led to weight loss (Hsu, Santhouse, & Chesler, 1991).

The eating disorder patient must be helped to recognize that symptoms have disastrous long-term consequences even though they provide shortterm gratification. For most patients, anorexia nervosa is a misdirected attempt to achieve mastery and well-being (Garner, 1986). Patients become genuinely motivated for recovery once they recognize that the effort required to maintain the disorder and its emotional consequences virtually preclude sustaining interpersonal and vocational goals (Haskew & Adams, 1989).

Two-Track Approach to Treatment

Garner and his associates (1985) recommended that the therapist adhere to a conscious two-track approach to treatment of anorexia nervosa throughout the course of therapy. The first track pertains to eating behavior and physical condition. The therapist must be aware of these at all times and plan specific

cognitive and behavioral interventions aimed at their normalization. The second track involves the more complex task of assessing the modifying misconceptions reflected in the client's self-concept deficiencies, perfectionism, separation or autonomy fears, and disturbed relationships. Often these issues are tied to beliefs about weight, but at other times they appear to be relatively independent (Garner, 1986).

Since both tracks are characterized by reasoning errors, faulty beliefs, and distorted underlying assumptions, they may be addressed using cognitive therapy principles (Freeman & Dattilio, 1992; Garner, 1986; Stone, 1980). An emphasis on the first track is required early in therapy since other contributing factors cannot be assessed until starvation symptoms and chaotic eating patterns are ameliorated (Hoffman, 1984; Schuyler, 1991).

The Therapeutic Relationship

Various systems of psychotherapy, including cognitive-behavioral, have acknowledged the role of the therapeutic relationship in promoting change. (Beck, Rush, Shaw, & Emery, 1979; Frank, 1973; Guidano & Liotti, 1983; Mahoney, 1974; Marmor, 1976). Clients with eating disorders need support and approval to make the potentially frightening behavioral changes that will be asked of them during treatment (Seligman, 1990). Developing therapist-client rapport seems integral to treatment. As Bruch (1982) notes, the individuality of these clients has often been denied in their families, and that should not happen in therapy. It is important that they be heard and encouraged

to develop seperateness and autonomy. Garner (1986) emphasized that a trusting relationship is crucial in cognitive-behavioral therapy since this approach places a premium on assessment of cognition, affect, and behavior through self-reported data. Moreover, the relationship provides a means for exanining distortions and misperceptions that the patient applies to her or his world.

Outcome Variables

Estimates of the death rate of person having anorexia nervosa have ranged from approximately 3% (Dally, 1967) to 9% (Herzog & Copeland, 1985) to 21% (Halmi, Brodland, & Rigas, 1975). In evaluating the treatment outcome of anorexic patients, it is important to carefully assess a range of intra- and interpersonal factors, as well as the normalization of weight (Schuyler, 1991).

Crisp, Kaulucy, Lacey, and Harding (1977) reported that anorexics of lower socioeconomic classes have a poorer prognosis and more marked psychopathology, often of a clear sexual nature, than do anorexics of higher socioeconomic classes. Halmi et al. (1975) found that early onset was related to a good prognosis, and Garfinkel, Moldofsky, and Garner (1977) reported that a favorable outcome was related to good premorbid education and vocational adjustment. Garfinkel, Moldofsky, and Garner (1980) also found a poor outcome in anorexics with a prehospitalization history of bulimia and vomiting.

Garfinkel and Garner (1982) reviewed 13 treatment outcome studies of long duration that evaluated a variety of nutritional

and psychological variables. The recovery rate averaged approximately 40% across studies, with another 30% classified as improved. Weight status was improved in 75% of patients in 16 studies reviewed by Hsu (1980). One of the most positive areas of adjustment at follow-up was vocational functioning (Schwartz & Thompson, 1982).

The treatment outcome for anorexic males generally appears to be less favorable than the outcome findings reported for females (Eckert, 1985; Brouwers, 1990). Crisp et al. (1977) speculated that overeating and vomiting are probably a more common feature among male than among female anorexics, and that the disorder develops in males in the context of prior massive obesity, gender identity problems, and a generally more marked psychopathological history.

Conclusion and Suggestions for Future Research

Anorexia nervosa involves a loss of body weight through self-starvation, body image distortion, and an intense fear of becoming obese that does not diminish with weight loss (Sue, Sue, & Sue, 1990). Anorexics in general, have poor self-esteem and may use their behavior as a way to control others.

Bruch (1973) cited the American preoccupation with slimness as a strong etiological factor in the increasing incidence of anorexia nervosa. Further, the overwhelming incidence of this disorder among females can be viewed in terms of societal definitions of physical attractiveness for women.

Although research on anorexia nervosa has not yielded a consistently effective treatment, studies of bulimia nervosa

have demonstrated successful therapeutic approaches: cognitive-behavioral, drug, family, and group therapy (Herzog et al., 1992). Cognitive-behavioral therapy appears to be the most effective treatment for bulimia nervosa (Freeman & Dattilio, 1992; Hoffman, 1984; McMullin, 1986).

The widespread phenomenon of dieting provides fertile soil for the development of eating disorders. There is a need for future research to focus on the dangers of extreme thinness and indiscriminate dieting with as much emphasis as has been given to health problems associated with severe obesity. Treatment methods designed specifically to address cognitive processes as well as eating behavior will continue to be of particular interest in the treatment of anorexia nervosa in the future.

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