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Contemporary psychotherapeutic interventions in patients with anorexia nervosa — a review

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Summary

Due to its ego-syntonic nature, anorexia nervosa (AN) is considered one of the most difficult mental disorders to treat. Patients are often reluctant to accept treatment, while a large group of those who receive therapy have a poor prognosis. Unfortunately, despite suffering from physical and psychosocial impairment, patients with AN are often reluctant to receive any intervention whatsoever. Recent years have seen the development of many new treatment methods for eating disorders in general, and AN in particular. Therapy of anorexia nervosa requires a multidisciplinary approach based on the "cornerstone" of psychotherapy. Despite the growing body of studies and publications concerning psychological treatment of AN, there is still a dearth of high-quality randomized controlled trials which could serve as the basis for developing guidelines in this area. This paper offers a compendium of knowledge on treatment standards recommended for AN, as well as on psychotherapeutic paradigms and programs. Most of the therapies presented herein have been empirically proven effective. Therefore, the paper may facilitate the selection of the most appropriate treatment choices, whether in outpatient or inpatient settings.

Key words: anorexia nervosa, psychotherapy, randomized controlled trial

Introduction

Anorexia nervosa (AN) is considered one of the most difficult mental disorders to treat. Patients are often reluctant to undertake a course of treatment, while many of those who do face a poor prognosis. According to the National Institute for Health and Clinical Excellence (NICE) [1] there is no first-line therapy for adults suffering from this disorder [see 2], while Steinhausen [3] has reported that AN treatment outcomes

have not improved over the past 50 years. According to him, only a third of patients with AN achieve long-term recovery, while in a fifth of them the disorder is chronic. The low effectiveness of current interventions for AN is attributable to a number of factors, including high drop-out rates [e.g., 4], the ego-syntonic nature of the illness [e.g., 5], patients' inability or reluctance to confront their personal, emotion-laden issues during therapy [e.g., 6], and the adverse effects of low body weight and malnourishment on cognitive processing [e.g., 7]. In the treatment of AN, nutritional rehabilitation and pharmacotherapy should be accompanied by psychotherapy [8].

Despite those reports, over the past several years we have seen the emergence of many new approaches to the psychotherapy of eating disorders, including AN. This paper presents the latest treatments as well as data on their effectiveness from randomized controlled trials (RCTs).

Cognitive behavioral therapy

The principles of cognitive behavioral therapy for AN were for the first time laid out by Pike, Loeb, and Vitousek [9] based on Beck's theory [10]. Research on disorder-maintaining mechanisms led to the development of a specialized program known as enhanced cognitive behavioral therapy (CBT-E) [11] designed for all eating disorders. In the case of anorectic patients, the CBT-E protocol involves three main stages. First, it helps patients realize the need to regain weight and encourage them to enter rehabilitation. The second goal is to restore normal weight, while addressing eating disorder psychopathology, including the maintaining factors. Finally, the third stage of CBT-E is designed to assist patients with sustaining normal weight. Underweight patients are recommended to take 40 CBT-E sessions over more than 40 weeks [12].

Evidence for the effectiveness of CBT-E is promising. A cohort study [13] evaluated the effect of 40 CBT-E sessions in 99 adults with AN. Two-thirds of them completed the course of treatment with an average weight gain of 7.5 kg (increase in BMI by 2.77). Also eating disorder psychopathology and general psychological characteristics were significantly improved. Another study [14] compared the focused form of CBT-E (CBT-Ef), which deals exclusively with eating psychopathology and the broad form of CBT-E (CBT-Eb), which is more complex and encompasses other aspects, such as interpersonal difficulties. The study involved 80 patients, 90% of which completed 20 weeks of treatment. Upon discharge, members of both groups revealed significant improvement in weight, eating disorders, and general psychopathology. In a study [15] analyzing the weight of 49 adult and 46 adolescent outpatients with AN receiving CBT-E, it was found that young individuals were much more likely to reach normal BMI levels (65.3% vs. 36.5%, respectively) and they needed much less time (approx 15 weeks) to do so (14.8 weeks vs. 28.3 weeks). Also two other studies conducted on adolescents with AN [16, 17] (the latter one was an RCT in an inpatient group) indicated high efficacy of CBT-E in terms of weight gain and alleviation of eating disorder

symptoms. Furthermore, improved quality of life was found in 196 outpatients aged over 16 undergoing CBT-E [18]. The promising data on CBT-E led to the publication of manual, commissioned by an NHS in England, recommending inpatient CBT-E as an evidence-based psychological intervention for adolescents with eating disorders [19].

Despite these encouraging results, researchers investigating this type of eating disorder psychotherapy still face considerable challenges, especially in terms of comparing CBT-E with other protocols in adult patients. So far, one RCT study – SWAN compared CBT-E with the Maudsley anorexia nervosa treatment for adults (MANTRA) and specialist supportive clinical management (SSCM) [20].

Interpersonal therapy

Interpersonal psychotherapy (IPT) was initially proposed by Klerman et al. [21] as a short-term treatment for patients with depression. It is based on the assumption that, regardless of disorder etiology, relationships are intertwined with symptoms, and thus improvement of interpersonal interactions should automatically alleviate the latter. IPT addresses both interpersonal problems which may have preceded the onset of the disorder, as well as those which maintain it or result from it. The standard version of IPT involves 12–16 weekly outpatient sessions (approx. 50 min each) divided into three distinct phases. First, the nature of and rationale for this treatment method are discussed and one or more interpersonal problems are identified. The patient and the therapist agree on the issues to be addressed. In the second phase, encompassing ten sessions, the patient is helped to assign his/her problems to one of four areas: grief, role disputes, role transitions, and interpersonal deficits. Finally, the last stage is designed to reinforce the outcomes and prevent a relapse. In IPT, AN is conceptualized as an expression of negative emotions linked to troubled relationships with others. In the course of therapy, the patient learns how to cope with frustration and tensions arising in relationships with other people and how to respond to emotions such as grief resulting from the loss of a loved one or negative feelings accompanying conflicts. Other IPT objectives include enhancement of self-worth and self-esteem in the patient to enable him or her to better function in interpersonal relationships.

IPT is a recognized and empirically proven intervention that may be used in conjunction with CBT-E. It has been found to produce good effects in patients with bulimia nervosa (BN) [22, 23] and binge eating [24, 25]. Taking into account similarities between AN and BN and the role of interpersonal factors in the etiological theories of AN, the application of IPT for AN is based on sound theoretical foundations [26]. However, further validation studies are needed.

Family therapy

Although family therapy is sometimes recommended for adults with AN [27], it is generally used in younger patients. The existing schools of family therapy include:

structural [28], behavioral [29], Milan systemic [30], strategic [31], feminist [32], attachment [33], solution-focused [34], and, recently gaining in popularity, narrative school [35].

Early theories concerning family therapy for individuals with eating disorders [28, 30, 36] assumed the existence of a specific type of family organization or interaction pattern underlying the development of AN. However that paradigm has been abandoned due to the absence of convincing empirical evidence for a link between a particular type of family functioning and AN [37, 38].

According to a new approach to family therapy for AN, family sessions are supposed to provide a context for, rather than a target of, change, which leads to paradigms that are based on cooperation and focus on the mobilization of family resources rather than changing the family [39]. Of special note is the approach first used at the Maudsley hospital in the 1980s, known as family-based treatment for AN (FBT-AN) [40], which is the most thoroughly explored treatment choice for adolescents with AN [1]. This therapy is principally aimed at regaining control over one's weight and eating habits, resolving structural problems in one's family, overcoming cognitive distortions, and ultimately, promoting autonomy [41]. FBT-AN differs from other treatment options for adolescents with AN in many respects. First of all, an individual with AN is perceived not only as a patient suffering from a serious disorder, but also as someone who needs assistance from his/her parents, especially in the area of eating management. This stands in contrast to many other theories positing that AN represents a struggle for control with intrusive and overbearing parents. FBT-AN emphasizes the fact that parents appear to seek control over their child due to the confusing nature of AN symptoms, the surprising change in the child's psyche accompanying the illness, and the sense of guilt stemming from their belief that they somehow contributed to the disorder.

FBT-AN has been evaluated in several studies. Eisler, Lock, and Le Grange, who conducted an RCT [42] on 220 adolescents with AN who received FBT-AN, reported significant health improvement. Another work [43] compared the family therapy protocol developed by the Maudsley research team and supportive individual therapy in four subgroups: adolescents with short-duration AN, adolescents with long-duration AN, adults with AN, and patients (mainly adults) with BN. All patients first underwent a three-month inpatient program. The most important finding was that members of the short-duration AN group who participated in family therapy demonstrated superior outcomes, which were sustained for 5 years following the end of treatment [44]. However, inconclusive results have been reported from other RCT studies [45, 46] comparing two forms of FBT-AN (in the first one sessions were attended by the patient together with his/her family, while in the second one the patient and his/her family were seen separately) [see 47]. Two other studies [48, 49] showed that both adolescents and their parents accepted FBT-AN and were satisfied both with the course and outcomes of the therapy.

It should be noted that until recently research into FBT-AN was hindered by various limitations, including the absence of a manual stipulating therapy guidelines,

with only two studies using a standardized treatment program [41, 50]. In light of the above, Lock et al. [40] wrote a detailed manual for FBT-AN following the Maudsley protocol. Currently, the consensus is that family therapy is the first-line treatment for adolescents with AN [1, 51].

Psychodynamic therapy

Focal psychodynamic therapy (FPT) is typically recommended for patients with eating disorders (and especially anorectic) with significant mental comorbidity, such as personality or severe interpersonal problems. FPT assumes that mental disorders may be linked to unresolved past conflicts, and in particular those stemming from childhood. Patients with AN are encouraged to analyze how early childhood experiences may have given rise to their eating disorder. The main aim of FPT is to arrive at more effective ways of coping with stress and negative thoughts and emotions. FPT usually takes 40 sessions entailing considerable motivation, perseverance, and time investment. It consists of two major therapeutic elements: an understanding of the significance of eating for the patient and establishing alternative ways of expressing one's emotions and anguish to enable the patient to "let go" of his/her eating disorder symptoms. In psychodynamic therapy, AN is perceived as a way of expressing inner conflicts concerning sexuality, rivalry, problems with self-reliance, or anything the individual may not accept about himself/herself. The patient–therapist relationship is the central element of therapy with its objective being the transference of significant events, thoughts, and emotions underlying the development of AN. The therapist assists in interpreting those factors, and the patient learns how to cope with and accept them [52].

An RCT study [27] comparing FPT with family therapy, cognitive analytic therapy (CAT), and a "routine" treatment for AN showed that FPT led to greater improvement (52%) than "routine" management (21%) with outcomes being similar to those obtained in family therapy (41%) and CAT (32%). Another study [53], conducted as part of the Anorexia Nervosa Treatment of OutPatients (ANTOP), compared FPT with CBT-E and standard treatment, at the same psychotherapeutic intensity. Various levels of weight restoration were observed in all experimental groups: FPT resulted in the most significant improvement at 12-month follow-up, while CBT-E was found to be most effective in terms of rate of weight gain and alleviation of eating disorder psychopathology.

Summing up, psychodynamic therapy is a promising treatment option for AN, but it still remains inaccessible to many patients, especially in Poland.

Cognitive analytic therapy

Cognitive analytic therapy (CAT) was developed in Great Britain by Ryle [54] based on other, classical treatments, including psychoanalytical as well as cognitive

behavioral therapies. Similarly to CBT, it focuses on the identification of negative thought patterns and aims to help patients with eating disorders understand specific psychological elements of their problems by considering past experiences and events. Already after several therapeutic sessions patients are ready to answer the question: *when did I first develop negative emotions linked to food and eating?* The main objectives of CAT are to replace negative behaviors with more helpful ones enabling transition to a healthy future without eating disorders, and to realize one's resources and their potential to improve one's everyday coping strategies. CAT consists of three stages: reformulation involving analysis of past experiences to explain the development of harmful behavioral and thought patterns; recognition by the patient of how those patterns contribute to AN, and revision consisting of the identification of changes which would enable the patient to exit the problematic patterns [54].

There is still insufficient evidence concerning the use of CAT in therapeutic work with individuals with eating disorders. However, one should mention the studies by Tanner and Carolan [55], who examined 100 patients undergoing CAT and found significant improvement both in individuals with AN and BN [see 27, 56; the second study was of RCT type]. The NICE guidelines [1] recognize the potential of CAT in the treatment of AN, but it is not described as a recommended therapy for BN and eating disorders not otherwise specified (EDNOS).

Conclusions

In the case of AN, therapeutic priorities should include weight gain and the management of core symptoms and comorbid mental disorders. To attain those goals, nutritional rehabilitation and pharmacological treatment should be supplemented by psychotherapy [e.g., 8]. Most inpatient programs are of multimodal nature (combine different types of therapy) and are based on a biopsychosocial model of the disorder. CBT remains one of the most widespread therapies for AN. According to research results, weight restoration is more effective and rapid in adolescent vs. adult patients receiving CBT-E. Currently, the first-line treatment for adolescents with AN is FBT-AN with empirically proven efficacy in that age group. However, its availability in Poland is limited. Finally, CAT offers a good alternative to long-term psychodynamic therapy. Unfortunately, despite suffering from physical and psychosocial impairment, patients with AN are often reluctant to receive any intervention whatsoever. Thus, the needs of these individuals require greater attention from researchers. The quality of their lives could in particular be improved by the development of pharmacotherapeutic management for their symptoms.

In sum, psychotherapy is critical to the treatment of patients with AN. While the multitude of psychotherapeutic approaches to AN may be at first confusing, the extensive literature on the subject, especially including reliable results of research, is very informative and helpful in determining an optimal treatment program. Undoubtedly, the most promising line of treatment involves multimodal therapy drawing on diverse

psychotherapeutic schools. Such programs are increasingly often offered also in Poland, especially in departments specializing in the management of eating disorders.

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