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Anorexia Nervosa

Focal Psychodynamic Psychotherapy

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Foreword

"I do not suffer and must then be well."

"Not only does she not sigh for recovery, but she is not ill pleased with her condition, notwithstanding all the unpleasantness it is attended with."

Lasègue (1873/1997, p. 495)

Much of what we know about the perplexing nature of and contradictions in the psychology of anorexia nervosa goes back to Charles Lasègue's careful and nuanced observations above. Based on these, he issued the following stark warning to clinicians:

> "Woe to the physician who, misunderstanding the peril, treats as a fancy without object or duration, an obstinacy which he hopes to vanquish by medicines, friendly advice, or by the still more defective resource, intimidation." (Lasègue, 1873/1997, p. 493)

In other words, never mistake anorexia nervosa for a passing phase that can easily be fixed.

Today, 150 years later, Lasègue's early descriptions are still very pertinent, as anorexia nervosa remains an extremely challenging disorder to treat. Psychological therapy of anorexia nervosa is hard, as the confluence of several factors creates a "perfect storm." Patients themselves present as inexpressive, or even outwardly bland, giving little away on how they feel. Typically they are very attached to their symptoms, minimize or down-play the seriousness of, or outright threat to their life, from their disorder and are highly ambivalent about treatment. In contrast, family members are understandably often extremely vociferous about their concerns and, in their desperation, may helplessly vacillate between bribery and threats to their relative. Clinicians themselves may feel overwhelmed, fearful, or torn between different feelings and courses of action.

This book is the first-ever evidence-based psychodynamic psychotherapy treatment manual for clinicians working with people with anorexia nervosa. It was written by leading experts in brief psychodynamic psychotherapy and in clinical management and research into psychobiology of anorexia nervosa. Based on their rich clinical and research expertise, these authors have modified the

psychodynamic treatment approach to tailor it to the characteristics and needs of this challenging patient group.

The efficacy of the manualized disorder-focused treatment approach presented here was confirmed by the multi-centre randomized controlled ANTOP study of outpatient treatments of anorexia nervosa, currently the largest study of its kind. Patients found the approach highly acceptable. The authors are to be congratulated on the development of this novel, evidence-based treatment manual, which constitutes a very useful clinical and research resource.

The present manual is primarily geared towards therapists with a psychodynamic treatment orientation. However, for therapists working with other treatment approaches it constitutes a valuable aid, to help inform about the unique characteristics and paradoxes of this devastating illness. The book opens insights into the preoccupations, anxieties, and broader inner world of patients with anorexia nervosa, which form the basis for the understanding of the specific psychopathology and are crucial for the development of a robust therapeutic relationship. To help decide on the main treatment focus in a given case, the starting point for the treatment is a detailed initial interview, using criteria of the Operationalized Psychodynamic Diagnosis system. Treatment is centred around a specific therapeutic focus and, combined with a particular therapeutic stance, is structured into three therapy phases. These phases are described in detail in the book, through illustrative case stories and examples of intervention strategies and helpful patient–therapist dialog. The manual is a wonderful resource for broadening therapist understanding and behavior in relation to key features of the illness. To address nutritional aspects of anorexia nervosa, a dietetic guidance document is integrated into the manual.

The evidence from the large ANTOP study, supporting the efficacy of this approach, together with the fact that the manual has been road tested by therapists from ten large eating disorder centres across Germany, attests to the practical applicability of this manual. It is hoped that in its current translation the manual will reach a wide readership and thereby broaden options for outpatient treatment of patients with anorexia nervosa in the English-speaking world. In addition, it is hoped that the manual will act as a catalyst for future psychotherapy research.

Taken together, there are many compelling reasons to wish this book wide dissemination and uptake amongst psychotherapists and researchers alike.

Ulrike Schmidt, December 2018
Professor of Eating Disorders, Head of the Department of Psychological Medicine, Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK

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Lasègue, E.-C. (1873/1997). On hysterical anorexia (a). *Obesity Research, 5*, 492–497.

Preface

Anorexia nervosa, unlike any other chronic illness, provokes a wide range of reactions in observers from "sympathetic identification with the affected person, to curiosity and surprise, or even admiration" (Habermas, 1994, p. 14).

Restrictive eating behavior and self-induced extreme underweight are the most obvious distinguishing characteristics of anorexia nervosa. Observed from a psychodynamic vantage point, patients can be seen to be attempting to stabilize their fragile feelings of self-worth, identity, and autonomy, with the key function of triumphing over their powerful feelings of "hunger" and denouncing other primary needs. Interconnected with this are feelings of uniqueness and exceptionality. The self-destructive consequences of their forced attempts at independence are an increasing state of being underweight, which is associated with social isolation and loss of positive interpersonal contacts, and which may lead to premature death. This set of dynamics, for its part, is disconcerting, and causes in turn an intensification of the patient's anorexic symptoms. The disease-related symptom of *restrictive eating behavior* is influenced by constitutional factors (genetic, epigenetic, endocrinological, etc.) and also includes sociocultural aspects.

The treatment of anorexia nervosa is seen as challenging, mostly because of the pronounced difficulty of winning patients over for treatment and having them adhere to a predetermined therapy setting. This is due to the strong fixation patients have on their symptoms (often combined with partial disease denial), which is accompanied by a pronounced avoidance, an extreme need for autonomy, and a strong subjective gratification in the symptoms. This is the reason the basic initial goal of every anorexia nervosa treatment plan is winning the patient over to the therapeutic process. In relation to treatment success, it is preferable that treatment begins in the early stages, especially because the chronic underweight tends to lead, together with psychophysiological adaptation processes, to the perpetuation of the anorexic symptomatology.

According to the national treatment guidelines for eating disorders of the American Psychiatric Association (APA, 2006), the Association of the Medical Societies in Germany (AWMF, 2011), and the UK National Institute for Health and Care Excellence (NICE, 2017), physically stable patients who are not suffering from

severe physical or psychological comorbidities should primarily receive outpatient psychotherapeutic treatment. Systematic analysis of the efficacy of such outpatient psychotherapy has recently been intensified. In the context of the promotion of psychotherapy networks in Germany and funded by the German National Ministry for Education and Research between 2006 and 2013, the efficacy of outpatient psychodynamic psychotherapy for the treatment of anorexia nervosa has been closely investigated. In a large, multicenter randomized controlled trial (the Anorexia Nervosa Treatment of Outpatients study, or ANTOP study), evidence from secondary analyses was collected that showed that a manualized and specifically tailored psychodynamic approach could be superior to treatment as usual (i.e., conventional treatments) at 1-year follow-up (see Section 6.2: The ANTOP Study).

Anorexia nervosa is characterized by multiple contradictory behaviors: the pursuit of an ideal autonomy and the wish for security, inner uncertainty and "splendid isolation", the hoarding of food and starving. These *aporia* constitute the fascination of anorexia nervosa and are all part of the challenge of treating this disorder. The goal of this manual is to provide a deeper understanding of the discrepancies in the inner experiential world of patients suffering from anorexia nervosa. At the same time, suggestions are made for disorder-specific adaptations of psychodynamic interventions and of the therapeutic stance. Our suggestions specifically focus on the repertoire of therapeutic behavior in order to expand the range of competences in the treatment of anorexia nervosa patients.

While we were developing this manual, many patients and their families, as well as our colleagues, showed interest in, and helped contribute to, our research. A heartfelt thank you goes out to them. Especially noteworthy has been the work of C. Growther, I. Eisler, and U. Schmidt from the Maudsley Group (Institute of Psychiatry, Kings College London, UK); the work of the members of the workgroup Anorexia Nervosa in generating the German guidelines for eating disorders (under the charge of S. Herpertz), and more specifically, those for anorexia nervosa (under the charge of A. Zeeck); and that of the therapists involved in the ANTOP study, in providing valuable suggestions for the manual during the workshops; as well as the contributions of H. Kächele, A. Sandholz, and T. Grande in sharing their extensive experience as supervisors for psychodynamic therapy in the treatment of anorexia nervosa patients.

This manual was first published in German in April 2014. Due to the considerable international interest in the landmark ANTOP study, published in the journal *Lancet* (Zipfel et al., 2014),

we decided to also publish an English translation of the manual. The current book represents a complete revision of the German publication and integrates the published research findings of the ANTOP study to date.

December 2018

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Contents

1 Description of the Disorder

1.1 Description

The eating disorder anorexia nervosa was first described in 1873

The case studies of the French physician Ernest-Charles Lasègue (using the term *anorexia hysterica*) and of the British physician Sir William Gull (*anorexia nervosa*), both published in 1873, constituted the first detailed descriptions of anorexia nervosa (Gull, 1873; Lasègue, 1873/1997). Both authors emphasized the psychological causes of anorexia nervosa and the missing disease insight and compliance of the affected individuals. Anorexia nervosa was thus the first autonomously defined eating disorder entity. Exaggerated fasting for religious motives had been documented even earlier, with case descriptions of ascetic, fasting saints going back to the 12th century.

The current use of the term *anorexia nervosa* (translating as "loss of appetite due to a nervous state") is misleading, since affected persons by no means lack appetite. On the contrary, patients suffering from anorexia nervosa of the binge-eating/purging type show fits of repeated overeating, similar to those of bulimic patients. Instead, it is the preemptive intense fear of gaining weight and the associated bodily changes that are the distinguishing symptoms. The *phobia of gaining weight* as the central motive for prolonged fasting was delineated as the core differential diagnostic criterion by the German-American psychoanalytic therapist Hilde Bruch. In her popular book *The Golden Cage: The Enigma of Anorexia Nervosa* (Bruch, 1978), Bruch helped form an awareness and understanding of the disease, not only for doctors and therapists, but also for the general public.

1.2 Definition

The diagnostic criteria of the *International Classification of Mental and Behavioral Disorders* (ICD-10; Chapter VF) of the World

2 Theories and Models

The development and maintenance of anorexia nervosa result, like other psychiatric disorders, from a complex interaction of intrapsychic, sociocultural, familial and biological factors. Evidence for a simple model of disorders that is purely monocausal and relies on a typical family constellation or on a specific genetic defect does not exist.

2.1 Psychodynamic Understanding

The psychodynamic theory of anorexia nervosa makes use of basic psychoanalytical concepts (such as drive psychology, object relations theory, ego psychology, and attachment theory) that have both an intrapsychic and interpersonal focus.

2.1.1 The Intrapsychic Dynamic

From a classical psychoanalytic perspective, the drive theory position of anorexia nervosa has been focused on for an extended period of time. Drive theory proposes that there is a shift from sexual impulses to oral impulses; sexual wishes and physical/genital sexuality are sublimated and denied through starvation. Bodily changes that coincide with sexual maturity, such as secondary sexual characteristics or menstruation, are deflected or delayed. In addition, sexual liaisons rarely exist in the relationships of anorexia patients. The developmental task of achieving independence from the parental home is delayed; the patient "stops time" and becomes an "eternal daughter." In her unconscious fantasies, she can thus remain an "integral object" for both the father and mother.

From its theoretical beginnings, the study of anorexia nervosa often included hints of a *pre-oedipal theme*. Thomae (Thomae, 1963) emphasized the singular importance of the oral phase of the disorder. Patients with anorexia nervosa often describe their mothers as overly protective, intrusive, extremely worried, or

3 Diagnosis

The basic concept of focal psychodynamic short-term therapy, when applied to patients with anorexia nervosa, is the focused treatment of a specific therapy theme (i.e., the focus), which is described in relationship dynamic terms and considers not only central conflict themes, but also structural weaknesses. This focus-oriented therapy requires thorough and precise psychodynamic diagnostics. The authors recommend using the interview guidelines of the OPD-2 (see Section 3.1: Operationalized Psychodynamic Diagnosis). This approach ensures that the central psychodynamic aspects of the patient's disorder are the main focus of treatment. In this sense, the therapy focus becomes an integrating and behavior-governing function that underlies the therapeutic process.

3.1 Operationalized Psychodynamic Diagnosis

The OPD-2 can be used to guide therapy

Operationalized psychodynamic diagnosis (OPD-2; OPD Task Force, 2008), as a system of reference, allows for a comprehensive personality-based diagnosis of the *patient's disease experience* (Axis I); typical maladaptive *interpersonal relations* (Axis II); and life-determining, dysfunctional *conflicts* (Axis III); as well as resources and deficits in structural psychological *ego functions* (Axis IV).

The OPD approach is psychodynamic. This means that aspects of repressed or defended motives and feelings, as well as the reenactment of early relationship experiences in the current therapeutic process (transference and countertransference), are taken into account. These aspects are gathered in the course of a *spontaneous* conversation, while the exploration of the patient follows the manual guidelines that include the following multiaxial approach.

4 Treatment

4.1 Treatment Setting

This manual presents the outpatient focal psychodynamic approach of psychotherapy for anorexia nervosa. It was conceived for the randomized controlled German ANTOP study described in Section 6.2, in order to operate within its framework. The length of treatment in this manual has been adapted to the number of outpatient sessions covered by health insurance in Germany – that is, roughly 40–50 sessions. An extension is indicated if the severity or duration of illness warrants it; this would prolong the treatment to a maximum of 100 sessions.

To establish the therapeutic relationship, it is recommended that 2 sessions be offered in the course of the first 2 months. From the third to ninth month of treatment, weekly sessions are required. During the closure phase, the session frequency should be reduced to one session every 2 weeks – which is to counteract the challenges that the anorexic psychodynamic places on the completion of the client–therapist relationship.

4.2 Therapeutic Framework

The therapeutic framework imparts stability and security

In both the inpatient and outpatient setting, a therapeutic framework with clear-cut treatment agreements sets the stage for success. The framework imparts security and supports weight gain. It also facilitates the examination of negative affects and the ubiquitous control theme. Typical agreements include weight parameters, meal structure, and accompanying medical examinations.

A regular meal structure of three main meals and three snacks should be aimed for as a central treatment goal. Due to the lengthy preexisting and self-imposed restrictive eating behavior, patients with anorexia nervosa find it difficult at the beginning of treatment to consume a normal portion of food. Main meals can therefore be divided into several smaller meals. Given favorable cooperation, a high-calorie drink supplement can be temporarily adopted until

5 Case Examples

The following sections cover some case studies for different types of anorexia.

Ms. P., Age 26, With Anorexia Nervosa, Binge-Eating/Purging Type

Ms. P., age 26, presented with anorexia nervosa of the binge-eating/purging type. After a preliminary interview at the psychosomatic clinic for outpatients, she agreed to treatment within the framework of the ANTOP study.

Psychodynamic Interview

A tall, slim woman in elegant and figure-flattering clothing arrives for treatment. At intake, she presents herself as flirtatious, though a pronounced uncertainty is noticeable. At the initial treatment session, the psychological strain this has on her is not immediately discernible. Her weight at the beginning of treatment is 50 kg (110.2 lb); her height is 171 cm (5 ft 7.3 in) (BMI 17.1 kg/m²).

The patient reports that her eating disorder began with restrictive eating behavior when she was 15 years old. Her starting weight then was 58 kg (127.9 lb); initially she lost weight until she weighed only 47.5 kg (104.7 lb). This weight remained constant for many years until last year when she again lost weight to a new all-time low of only 40 kg (88.2 lb) (BMI 13.7 kg/m²). After an initial phase of purely restrictive eating behavior, pronounced bulimic binge-eating/purging symptoms developed at about the 2-year mark. The patient reported multiple binge-eating/purging attacks per day, which occurred not only at her workplace during the day, but also at home when her boyfriend was not present. When asked about a possible trigger for the eating disorder, the patient reported being on the swim team during that stage in her life, but that she felt excluded from the team of her older girlfriends.

6 Efficacy

6.1 Research Background

The scientific evaluation of treatment plans for anorexia nervosa is difficult because the illness raises various therapeutic and methodological obstacles that can occur when treating anorexic patients under the parameters of a study. The realization of a clinical study concerning anorexics poses challenges. The following are examples of typical obstacles:

The realization of a clinical study concerning anorexia nervosa poses challenges

1. In the classical research design regarding the efficacy of a treatment, patients are usually randomly assigned to either the intervention or control group (i.e., RCT = randomized controlled trial). Since the reality of anorexia nervosa is such that medical complications are often imminent (caused by a dangerously low BMI), a control group that makes a patient either wait for treatment or receive an inadequately supportive therapy is not a feasible option. Such studies are currently viewed as unethical. Consequently, previous studies have, at times, resulted in a high rate of premature termination in the control groups.
2. The illness has a low prevalence rate. Recruiting enough patients for an RCT is expensive and requires the participation of several study centers.
3. Many anorexia nervosa patients are ambivalent about inpatient or outpatient treatment. Due to this reluctance, recruitment for an RCT can be difficult. Then again, there is the possibility of a high dropout rate. This can bias the results of the study.
4. In the course of assessing outpatient treatment, and because of severity of illness, physical complications can occur that require admission to inpatient treatment. Findings from previous research demonstrate that such hospitalizations can lead to high dropout rates. Thus, for example, Halmi and others (2005) suggested that study protocols for RCTs regarding outpatient therapy of anorexic patients should allow for hospitalization for a predefined, limited time period (Halmi et al., 2005).
5. To date it remains unclear what the specific components of therapy are that lead to recovery for anorexic patients. We

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8 Appendix: Tools and Resources

Appendix 1: Nutrition Guidelines for Patients With Anorexia Nervosa

Appendix 2: Weight Curve

Learn to apply focal psychodynamic psychotherapy – shown to produce lasting changes for patients with anorexia nervosa.

This manual presents an evidence-based focal psychodynamic approach for the outpatient treatment of adults with anorexia nervosa, which has been shown to produce lasting changes for patients. The reader first gains a thorough understanding of the general models and theories of anorexia nervosa. The book then describes in detail a three-phase treatment using focal psychodynamic psychotherapy. It provides extensive hands-on tips, including precise assessment of psychodynamic themes and structures using the Operationalized Psychodynamic Diagnosis (OPD) system, real-life case studies, and clinical pearls. Clinicians also learn how to identify and treat typical ego structural deficits in the areas of affect experience and differentiation, impulse control, self-worth regulation, and body perception. Detailed case vignettes provide deepened insight into the therapeutic process. A final chapter explores the extensive empirical studies on which this manual is based, in particular the renowned multicenter ANTOP study. Printable tools in the appendices can be used in daily practice. This book is of interest to clinical psychologists, psychotherapists, psychiatrists, counselors, and students.

"This rich compendium of clinical practice and research, illustrated with case descriptions and treatment tips, is essential reading for all clinicians working with people with anorexia nervosa."
Janet Treasure, OBE, PhD, FRCPsych, FRCP, Consultant at South London and Maudsley Hospital and Professor at King's College London, UK

"This book provides scientific evidence for an approach that has a long-term impact on one of the most vexing psychiatric problems – anorexia nervosa. Anybody working or wanting to learn to work with these patients should read this."
Jacques P. Barber, PhD, ABPP, Professor and Dean of Gordon F. Derner School of Psychology at Adelphi University, NY, USA

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