Anorexia nervosa and bulimia nervosa — a psychotherapeutic cognitive-constructivist approach

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ABSTRACT
Of the eating disorders, anorexia nervosa and bulimia nervosa are the ones that have made adolescent patients—often females and aged younger and younger—seek for help. This help is provided through a multidisciplinary treatment involving psychiatrists, psychologists and dietists. Psychotherapy has shown to be an efficient component for these patients’ improvement. The present article aims at presenting a proposal of psychotherapeutic treatment based on a cognitive-constructivist approach.

KEYWORDS
Anorexia nervosa; bulimia nervosa; cognitive-constructivist approach

Anorexia nervosa
Eating disorders (anorexia nervosa, bulimia nervosa and their variants) are psychiatric conditions that mainly affect female adolescents and young adults (although an increase of children looking for treatment has been recently noticed), resulting in great biopsychosocial losses with high morbidity and mortality (Doyle & Bryant-Waugh, 2000).

Anorexia nervosa is characterized by intense weight loss by means of self-imposed strict diets in a wild attempt to become thin, body image distortion, and amenorrhea. In 1874, William Gull described three patients presenting with a restrictive anorexic condition, and he termed it as ‘hysteric aepsia’. The clinical condition featured weight loss, amenorrhea, bradycardia, low body temperature, edema on the lower limbs, obstipation, and peripheral cyanosis (Cordás, Guimarães, & Abreu, 2003).

Brunch (1962), in the 1960s and 1970s, was the first author to mention body image distortion as a disorder that the anorexia nervosa patient show in body perception.

As of the 1970s, clinically evaluated patients exhibited excessive fear of gaining weight, which is the first step to incorporate the ‘morbid fear of becoming fat’ as a psychopathological characteristic of anorexia nervosa, along with weight loss, body image distortion, and amenorrhea (Russell, 1979).

Low self-esteem and body image distortion are the major components that reinforce the uninterrupted seek for weight loss, leading to the practice of physical exercises, fasting, and the use of laxatives or diuretics in an even more intense fashion (Garfinkel & Garner, 1982; Garner & Garfinkel, 1981).

Patients with the purgative subtype of anorexia nervosa—that is, patients having bulimic episodes and some purgation practices (vomiting, diuretics, enemas, and laxatives)—are more impulsive, have different personality aspects from patients only using restrictive practices, and are more perfectionist and obsessive (Garner, Garner, & Rosen, 1993).

Bulimia nervosa
Bulimia nervosa (BN), in turn, is characterized by high, fast food ingestion and a sensation of loss of control—the so-called bulimic episodes. These are accompanied by inadequate compensatory methods to control weight, such as self-induced vomiting (in over 90% of cases), use of drugs (diuretics, laxatives, appetite suppressants), diets and physical exercises, caffeine abuse, or cocaine use (Fairburn, 1995).

BN description, as we know it today, was outlined by Russell in 1979 when reporting on 30 female patients with normal weight, terror of weight gain, bulimic episodes, and self-induced vomiting. Because

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these patients had shown anorexia nervosa in the past, Russell initially considered that the bulimia was a sequel, a ‘weird’ variant of anorexia nervosa (Russell, 1979).

Fairburn (1991)—as well as other authors, including Russell—later described the autonomous nature of that condition, as only 20–30% of bulimic patients had a previous history of anorexia nervosa, usually of short duration.

As previously mentioned, BN is characterized by high, fast food ingestion and a sensation of loss of control—bulimic episodes are typically accompanied by inadequate compensatory methods (Hetherington & Rolls, 2001).

The main characteristic of BN is the presence of bulimic episodes, with an average ingestion of 3000–4000 calories per episode being reported, although episodes with an ingestion of up to 20,000 calories have been reported (Mitchell, Crow, Peterson, Wonderlich, & Crosby, 1998).

**Cognitive-constructivist psychotherapy model**

The cognitive model assumes that there is, between the world and the individual, a mediation of the thinking activity; this means that the way individuals feel, and consequently, behave is a product of a continuous cognitive activity that assigns meanings to events occurring in the outside world. Thus, the cognitive-constructivist model questions the superiority of thinking over feeling and acting and proposes the opposite: our cognitive constructions would be a product of the emotional organization that is tacitly developed about reality (Abreu & Shinohara, 1998).

In the constructivist conception, meanings are built by following the conceptual (thinking) processing and experiential (emotions) processing rules. In the latter, the meanings created in our conscience stems from the activity of perceiving the contents that are tacit (or body-related), in a preconceptual, implicit condition. At this level, we do not interpret situations from a logical point of view, but rather from an emotional perspective, which means that the meaning resulting from an event is based on the experiential principles from situations. Therefore, once the information is ‘felt’, this content will be translated into aspects related to ‘comfort or discomfort’ and ‘safety or threat’ of a situation. An example is the complaints most commonly heard in our offices. We often listen, in various situations, comments such as: ‘I’m feeling overwhelmed’, ‘that situation makes me feel a tightness in the chest’, ‘I feel as if I was carrying the world on my back’, and so on. Therefore, many of the interpretations we make of events initially come from body-related impressions (also called ‘tacit’ or ‘sensorial’), which are later integrated and explained by our reasoning (Abreu, 2001).

For each person, the construction of reality accounts for organizing his or her experiences (conceptual processing and experiential processing) in order to make it a balanced system. Being well-balanced means to keep coherent the perception of the world, the others, and the self.

For constructivism, human development is a never-ending process. This development, in turn, occurs from the continuous reorganization of the system. The disorders are acute or chronic episodes of disorganization, although not being enemies of mental health and overall well-being (Mahoney, 1998).

Therefore, we can understand the eating disorders as a result of the disorganization in how patients build reality. However, this is a necessary disorganization to keep balance, i.e. keep the coherence in how to think, feel, and act.

**Bulimia nervosa**

*Psychological aspects and psychotherapeutic treatment*

Patients with bulimia nervosa (BN) have a variety of maladaptive thoughts and emotions towards their eating habits and body weight. Overall, we can say that patients with BN have a fluctuating self-esteem, which makes them believe that one of the ways to solve their personal insecurity problems is through a well-designed body, and to achieve their goal, they end up by developing diets that are impossible to follow. In other words, they try to ‘heal’ an emotional problem by adopting imperative strategies to lose weight and, as a result, develop extreme attitudes based on the idea that being thin is one of the shortest pathways to happiness. They mistakenly believe that having control of their actions will provide them with emotional security.

It should be reminded that remaining deprived from caloric food for too long is not one of the easiest tasks; therefore, each time bulimics start a restriction period, a real battle takes place. As it is impossible to keep oneself in an extreme dietary condition for long periods (making the caloric reduction process even more severe), eating imbalances occur after long-fasting periods, resulting in binge-eating episodes, characterized by a total lack of control that can only be compensated, in these patients’ opinion, by using
laxatives, diuretics, excessively exercising, or even through self-induced vomiting.

As they cannot feel satisfied, they keep ingesting food until they feel stuffed. This sensation of discomfort leads these patients to purgation. After such ‘purgation’ periods, the caloric restriction is resumed. The result is inevitably a new fall marked by lack of control and a successive period of purgation. (Figure 1) Therefore, this emotional swinging is one of the factors characterizing BN.

The psychological assumptions that are involved in these behaviors are based on the idea that ‘being thin equals being attractive, successful or happy’. It turns out that such quest does not occur exclusively due to body-related causes. It is common to encounter patients with BN showing chaotic attitudes, not only those related to their eating habits, but also in a disorganized lifestyle.

It is thought, therefore, that one of the potential causes involved in the etiology of this condition is the very personal disorganization. Some clinicians even suspect that the attempt of eating regulation and control is an attempt (although unsuccessful) of organization and stability. This is the reason why so many psychological treatment interventions are based, among others, on the offering of ‘structured’ problem-solving strategies, as they convey the idea of a firm ground for change.

Should we describe such behaviors in metaphorical terms, we would use the idea of a (emotional) roller-coaster. In this sense, the lack of order pervades several other aspects, not only those described above. We will easily encounter individuals destined to deprive themselves from long-term romantic relationships (because they do not feel attractive enough—rather, they feel ‘fat’), intercalating other periods in which the affective demeanors are extremely intense, and the lack of parameters or common sense becomes one of their benchmarks. Family relationships do not fall behind, as they exhibit the same relationship assumptions—parental exchanges are mostly marked by low levels of complicity and interpersonal respect. BN patients’ families are described in the literature as disturbed, poorly organized, having difficulty to express warmth and care (Lask, 2000). At work, the same complaints are seen; many patients do not feel they have found ‘the activity of their lives’, often engaging in routines that deprive them from interest and pleasure.

With the foregoing, it is not surprising that such patients look for something they do not even know what it is. The search for perfection (self-demand) is, therefore, one of these patients’ characteristics, because, as the environmental instability becomes a constant companion, the lack of a fixed parameter or a more solidified value makes the personal (although seasonal) diligence a primary element in defining this incomplete identity (daughter, woman, professional, etc.).

As we are briefly mentioning some factors linked to the emotional framework of individuals with BN, some psychological aspects are noteworthy: (a) low self-esteem; (b) ‘all or nothing’ thinking (i.e. functions through opposite values); (c) high anxiety; (d) perfectionism; (e) incapacity of finding forms of pleasure and satisfaction; (f) seeking problems everywhere; (g) high demand; and (h) incapacity to ‘be happy’.

The treatment developed by C. N. Abreu (one of the authors of this text) currently consists of 18 weeks and is based on the cognitive-constructivist model of psychotherapy Table 1. At each meeting, a thematic axis is addressed, enabling patients to progressively retake the control and management of their emotional lives, and consequently, reorganize their eating habits. This way, a work plan is established, and the participating patients are evaluated on a weekly basis. The

| Week 1 | Program introduction and inventory application |
| Week 2 | Understanding the hunger |
| Week 3–4 | My hunger and its consequences: The beliefs involved |
| Week 5–6 | The eating disorder and/in my life |
| Week 7 | The idealized body image |
| Week 8–9 | The subjective perception of the body image |
| Week 10 | The change process: Who and how do I want to be? |
| Week 11 | Understanding the “bad” emotions |
| Week 12–13 | Transforming emotions |
| Week 14–15 | Reconstructing the personal paradigm |
| Week 16–17 | Reconstructing the personal paradigm, self-evaluation development, and inventory application |
| Week 18 | Process closing: Feedback |

Table 1. Cognitive constructivist program for bulimia nervosa treatment.

Source: Abreu (2002b).
sequence of thematic axes in the psychotherapeutic program is the following:

At the end of the program, a multidisciplinary evaluation is conducted by following the criteria established by AMBULIM, with nutritionists, psychiatrists and psychologists being involved. From the joint evaluation, patients may: (a) be discharged; (b) be referred to an 18-week maintenance program targeting other themes; or (c) restart the program, in case of low compliance level.

**Anorexia nervosa**

*Psychological aspects and psychotherapeutic treatment*

Anorexia nervosa (AN) is another type of eating disorder that, when compared with bulimia nervosa, has dimensions requiring more seriousness in the treatment. From the oldest publications in journals up to these days, the existing articles—which are few and might provide description, prognosis of improvement or even recovery rates—have mostly discouraging results.

The reasons for the paucity of outcome studies of treatments include: (a) low incidence of the disorder; (b) difficulty in recruiting patients perceiving themselves as having a significant problem; (c) disorder severity; and (d) high drop-out rate from the outpatient therapy. Therefore, the available studies of AN still present contradictory data, although most of the long-term outcome studies suggest much more limited success. To cite just one example, broadly reviewing more than 100 studies, about 50% of patients only ‘totally recover’ (meaning the reestablishment of the weight, the normalization of eating behaviors and the return of regular menstrual periods). Other 20–30% experience partial recovery, characterized by some eating behavior residue or disorder and inability to keep the normal weight. And, finally, in the remaining 10–20%, the disease takes a chronic form, with no signs of remission (Zipfel et al., 2000; Lowe et al., 2001; Keski-Rahkonen et al., 2007).

More recent studies suggested that, in the short-term treatment, the majority recovered their weight with a single purpose: to be discharged from hospital. Therefore, we can easily notice that we are facing one of the most refractory populations to any type of help. In this sense, what we try to achieve with AN patients is to: (a) reestablish normal eating patterns (as 50% of anorexics exhibit compulsive eating, this is one of the main goals of treatment interventions); (b) promote self-regulation of body weight; (c) reduce (and eliminate) purgative or restrictive attitudes; and finally; (d) create motivation for change (Cordás et al., 2003).

One of the most frequent questions when working with anorexic patients is, ‘Why is it so difficult to create motivation for change?’. Because such patients develop negative attitudes towards food for long periods, these ‘habits’ interfere so much with the recovery process that the disease reemerges when any future situation leads the patient to live some form of crisis—that is, we are facing a true body fixation. While in the treatment of BN we can assure to patients that the improvement of their condition has virtually no significant effects on their body weight, in NA cases it is not possible to offer such assurance, once this is one of the treatment goals and, at the same time, positions these patients in confrontation with what they most fear.

Therefore, it is no surprise that patients start treatment with little or no intention to ‘progress’. Rather, practitioners should be surprised if there is not some form of sabotage to the treatment. Perhaps it seems funny that we use such a heavy expression, but we should stress that such behavior stems from the fact that anorexic patients, contrary to what happens to BN patients, describe increased self-esteem at each kilogram that is lost. In conclusion, it is not surprising that they are described in the literature as ‘resistant’, ‘defiant’, or ‘intractable’.

It may seem something polemic, but two reasons are pointed out to justify such: a) patients ‘know’ they need help, but they fear what a body change might cause, and b) the eating restrictions they undergo create malnutrition over time, which in turn, start to progressively generate inevitable cognitive deficits, depriving them from the normal ability to understand their problems. We are then involved with the treatment of a disease that generates physical, emotional and social limitations (Abreu, 2002a).

The most commonly described psychological characteristics include: (a) low self-esteem; (b) sense of hopelessness; (c) unsatisfactory development of the identity; (d) tendency to look for external approval; (e) extreme sensitivity to criticisms; and (f) conflicts relative to autonomy versus dependence themes. Ironically, when questioned about their condition and their resistance to change, anorexics promptly list a number of justifications for their behavior, namely: ‘I like the way I feel when I am thin’, ‘I am more respected and receive more compliments’, ‘what others try to do, I show that I can do better’, ‘I like the attention I receive’, ‘I like the clothes that I am
able/can wear’, ‘I am better off this way’, ‘having fat in my body is really gross, and I do not have this problem anymore’, ‘my family and my doctor worry about me’, ‘I can keep people away’, ‘I do not need to have my periods’, ‘I feel as if I was in touch with the suffering in the world’, ‘I feel healthier and more energetic when I have a light weight’, ‘I feel more confident and capable when I am thin’, ‘I like the sensation of self-control’, ‘I feel more powerful when I do not eat’, ‘when I am thin, I realize things better’, and ‘I feel especial, pure and distinguished’. This means that, for these patients, the disadvantages are clear, such as ‘becoming thin takes a lot of time and energy, and people feed me up because of that’, ‘I hate to think about food all the time’. During the most acute phases, such individuals are still trying to pursue their disease, and the goal is to become an even thinner person, and therefore, show off their success (Abreu, 2002a).

Taking all together, we can clearly note that AN is a complex disease that imposes big challenges at each treatment stage, and in the best scenario, individuals with anorexia nervosa are continuously ambivalent in searching treatment. They remain resistant to any type of external intervention, which contributes to one of the highest treatment refusal and early drop-out rates. Those remaining in treatment often do not comply with the instructions, and when they do comply with the first interventions, there is a high risk of relapse (Cordás et al., 2003).

Results suggest that 70% of patients treated with cognitive therapy did not satisfy the diagnostic criteria for anorexia nervosa anymore at six months, although they had maintained significant low weight, on average (Fairburn, Marcus, & Wilson. 1993). However, in a comparative study that evaluated the relative efficacy of family-based treatment (FBT) and adolescent focused individual therapy (AFT) for adolescents with anorexia nervosa on full remission, the findings suggest that FBT is superior to AFT for adolescent AN, though AFT remains an important alternative treatment for families that would prefer a largely individual treatment (Lock et al., 2010).

Conclusions

The psychological exploration and change do not occur by just replacing dysfunctional schemas for more functional schemas of thinking; rather, they first occur by exploring the dialectic process of probable contradictions existing between (the individual’s) experience and concept (which is developed by the individual after having lived the ‘experience’). By integrating them, the (re)construction of a global meaning is favored. At all times, we first experience something so that we can later talk about it. That is why a logical argument hardly ever shows to be effective in the change process. Therefore, if we are to produce some change that is more effective, we should always start from the emotional (and experiential) levels of the situations (Abreu & Roso, 2003).

In this sense, the cognitive-constructivist therapy goals in eating disorders include the gradual development by the patient of a better response skill to challenging environmental pressures and the modification of the emotional patterns (not only the negative thought) towards eating and body shape and weight. Because the emotional reactions are the oldest companions we have in the human life (impacting memory, mood, and task-solving skills), understanding and regulating them is one of the most desirable goals in this form of psychotherapy (Abreu & Roso, 2003). Emotional dysfunctions and disorders emerge when individuals are not authorized to recognize, feel, or even validate certain emotions, which contributes to the emergence of eating disorders.

Disclosure statement

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