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Cognitive-Behavioral Therapy and Other Short-Term Approaches in the Treatment of Eating Disorders

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Over the past fifteen years significant strides have been made in identifying, developing, and implementing therapeutic strategies used in the treatment of eating disorders. At the same time, the exigencies of providing psychiatric treatment in this era of managed heath care have necessitated finding clinically effective, yet cost-effective, short-term approaches. One treatment that has emerged is cognitive-behavioral therapy (CBT), and a growing body of empirical evidence has clearly demonstrated its effectiveness in the treatment of bulimia nervosa (Agras et al. 1992; Fairburn, Agras, and Wilson 1992; Garner et al. 1993) and binge eating disorder (Agras et al. 1997). Moreover, although initially thought to be an ineffective therapeutic approach for anorexia nervosa, a number of recent articles have suggested that, with modification, CBT can be successfully used in treating anorexia as well (e.g., Garner, Vitousek, and Pike 1997). This chapter describes cognitive-behav-

ioral therapy, along with other current short-term treatments for eating disorders.

COGNITIVE-BEHAVIORAL THERAPY AND BULIMIA NERVOSA

Cognitive-behavioral therapy was first introduced by Beck and his colleagues (1979) and was initially used in the treatment of depression. The use of CBT in bulimia nervosa was first conceptualized by Fairburn (1981), and over the years a detailed and periodically revised treatment manual has evolved (Fairburn, Marcus, and Wilson 1993), which has given clinicians a blueprint for treating eating disorders using this approach.

The CBT model emphasizes that both cognitive and behavioral factors are at play in maintaining bingeing behavior. Since bulimics overvalue body weight and shape, the stage is set for the individual to restrict food intake in order to attain or maintain the goal of the desired physical appearance. This restriction then leads to being susceptible to loss of control over eating, which results in bingeing.

Self-induced vomiting and other forms of inappropriate weight control attempt to compensate for the calories consumed during the binge. The purging behaviors persist because they lessen the anxiety surrounding weight gain. However, as a result of the binge/purge behavior, the patient feels guilty and suffers from a compromised sense of self. This model for bulimia nervosa suggests that treatment must not only address the presenting behaviors of binge eating and purging but must also assist the patient in replacing dietary restriction with a more normal eating pattern. In addition, it must also help modify the dysfunctional thinking and feelings regarding the significance of body shape and weight (Wilson, Fairburn, and Agras 1997).

PRELIMINARY CONSIDERATIONS

Although CBT has demonstrated a high degree of efficacy in treatment outcome studies, certain cohorts of patients would not be considered suitable candidates for therapy (see, e.g., chapter 11 below). Co-morbidity of substance abuse or dependence would preclude a

patient from CBT, as would a concurrent diagnosis of severe depression (Agras and Apple 1997). These conditions would interfere with the patient's ability to adhere to the treatment program; so before attempting CBT, it is preferable to begin therapy by treating the underlying addiction or mood disorder first.

Treatment typically lasts about twenty weeks and consists of nineteen sessions. CBT has three clearly delineated stages: Stages 1 and 2 consist of eight sessions each, and Stage 3 is three sessions. Each session lasts up to fifty minutes, and the therapist adheres strictly to the time frame of sessions.

CBT focuses on the present and the future, and is semi-structured and problem-oriented in nature. As with all therapy formats, a good therapist-patient relationship is essential for recovery. The patient has an active role in the treatment sessions, and the success of CBT depends considerably on the patient's ability to remain motivated to follow through on homework assignments. The therapist has an active voice in the sessions and provides didactic information, support, guidance, and encouragement. Before beginning Stage 1, a thorough psychiatric evaluation should be completed to assess the patient's suitability for the CBT program.

Stage 1 (Sessions 1–8)

The two major aims of Stage 1 include orienting the patient to the cognitive-behavioral approach and replacing the binge/purge behaviors with a more stable pattern of eating. In outlining the rationale underlying the CBT approach to treatment, the therapist explains the vicious cycle that occurs within the constellation of bulimic symptoms and their interrelationships (strict dieting, bingeing and purging, extreme concern about weight and shape, and low self-esteem), and how it perpetuates the eating disorder. In the first session the therapist also introduces self-monitoring. The patient is instructed to keep a record on a daily food record sheet of everything she eats. The time of day, the food eaten, whether a binge or purge occurred, and the associated thoughts and feelings are all noted and then discussed with the therapist in the following session. The self-monitoring serves two purposes: (1) It provides data for the therapist regarding the patient's eating style and con-

comitant emotional states; and (2) it increases the patient's awareness of what is being eaten and under what conditions. In addition to self-monitoring, the patient is also instructed to weigh herself once a week.

During Sessions 3 to 8, the therapist introduces behavioral strategies that are geared toward regaining control over eating. These strategies include self-control and stimulus control. In the first session, the patient is asked to identify high-risk situations that may trigger a binge and then to make a list of alternative activities that are enjoyable and feasible but at the same time incompatible with binge eating. These behaviors may include talking with a friend on the phone, taking a shower, walking, or going to a store. Stimulus control is a technique whereby the patient attempts to control the environment by imposing certain rules about eating. Such measures would include restricting eating to one part of the house, limiting the quantity of binge foods in the house, practicing leaving food on the plate, avoiding food shopping when hungry, and always using a shopping list. This self-control technique is especially helpful in the early stages of treatment, when impulse control is somewhat tenuous.

Educating the patient about weight and eating is another task that is completed in Stage 1 of CBT treatment. Areas discussed include body weight and the concept of the body mass index, the physical consequences of dieting, laxative use, and self-induced vomiting (and their ineffectiveness in regulating weight), and the adverse effects of dieting. This didactic approach is critical as it dispels the myths patients frequently have concerning eating and body weight, and lays the groundwork for altering the patient's perceptions and cognitive beliefs about food. In addition, the patient is asked to restrict eating to three meals and two or three snacks per day. This eating-by-the-clock strategy is employed to disrupt the cycle of overeating followed by food restriction that so frequently characterizes the bulimic's eating habits.

In a high percentage of patients, Stage 1 results in a significant reduction in the frequency of binge eating and purging. If, however, binge eating continues to occur at least once a day, then Stage 1 should be extended. If significant improvement has not occurred by Session 8, then this approach should be stopped and another therapeutic model introduced.

Stage 2 (Sessions 9–16)

While continuing to discuss the importance of regular eating patterns, the review of the monitoring sheets, weekly weighing, and the use of self-control and stimulus-control techniques, Stage 2 begins to address dieting in general, concerns about body shape, and the cognitive distortions that accompany bulimia nervosa. The sessions shift toward a more cognitive focus and include training the patient to problem-solve everyday situations that contribute to the continuation of bulimia symptomatology.

By the beginning of Stage 2, the patient has become acquainted with the notion that rigid dieting predisposes the individual to binge eating. The next step is to assist the patient in identifying what foods are eaten and how much is consumed. The patient is asked to generate a list of foods to be avoided and put them in rank order. During Stage 2 the patient should progressively reintroduce these "forbidden foods" into her diet, beginning with the least objectionable ones. The goal of this exercise is to demonstrate to the patient that a reasonable degree of control can be attained over foods considered frightening. Restriction of the total amount eaten is addressed in a manner similar to that for avoiding certain foods. Through careful assessment of the monitoring sheets, it can be determined whether the patient is eating too little. If this is the case, the patient should be urged to consume at least 1,500 calories a day.

As binge-eating episodes become intermittent, the patient and therapist then must identify the precipitants or triggers for bingeing. These may include interpersonal difficulties, self-esteem deficits, mood disturbances, or even specific thoughts. Once they are identified, CBT is designed to allow the patient to develop behavioral and cognitive skills for coping more effectively with these situations without the need to rely on bingeing and purging. This is accomplished by the therapist assisting the patient in improving her problem-solving skills using a seven-step process (see Fairburn, Marcus, and Wilson 1993), which first identifies the problem, considers the various possible solutions, and then assesses the feasibility of each solution. Once a solution is settled on, the steps needed to carry it out are defined and then acted on. Finally, the day after the solution

has been carried out, the patient scrutinizes the entire sequence and evaluates the success or failure of the endeavor. The goal of this therapeutic task is to assist the patient in developing a framework for problem-solving skills that can be implemented whenever difficulties arise.

One of the most common triggers for inducing binge eating is disordered thinking (e.g., believing you are overweight when you are not or believing a five-pound weight gain will be evident to everyone). Often, however, the patient remains unaware of the thinking patterns that contribute to the onset of a binge episode. At this juncture in treatment, the therapist begins to address the underlying problematic thoughts and attitudes that perpetuate the eating disorder. The patient's concern about shape and weight is especially susceptible to faulty cognitive patterns such as dichotomous thinking (something is either all good or all bad, nothing in between). Other types of disordered thinking frequently seen in eating disorder patients include overgeneralization, catastrophizing, selective abstraction, and magnifying negatives and minimizing positives (Agras and Apple 1997). Dysfunctional attitudes are also a critical aspect of the psychological landscape that contribute to maintaining eating disordered behavior. Often the bulimic patient believes that in order to be happy, successful, and attractive, you must be thin. If you are fat, then you are depressed, viewed as a failure, and ugly. These aberrant thinking and attitudinal styles are confronted in CBT treatment using cognitive restructuring techniques (see Hawton et al. 1989).

The patient is asked to identify a problematic thought that she believes may contribute to the binge-eating disturbance. The thought itself is noted and written down, followed by objective evidence to support and refute that thought. The therapist assists the patient in developing a reasonable conclusion based on their exploration of the evidence. Finally, the patient determines a course of action that will direct the behavior.

Stage 3 (Sessions 17–19)

The third stage, when sessions are biweekly, focuses on strategies to prevent relapse. The major goal is for the patient to learn how to

anticipate future difficulties and apply both the problem-solving and cognitive restructuring skills that have been acquired in order to circumvent a recurrence of binge/purge behaviors. At the same time, however, it is important that the therapist point out to the patient that under severe stress, binge-eating behaviors may be revisited but can be viewed as lapses rather than a full-blown relapse. In addition, each patient completes a written maintenance plan that can be followed once therapy has ended.

COGNITIVE-BEHAVIORAL THERAPY AND BINGE-EATING DISORDERS

Although binge-eating disorder was first described by Stunkard in 1959, it only became part of the official psychiatric nomenclature when, in 1994, it was included in Appendix B of the fourth edition of the *Diagnostic and Statistical Manual* (*DSM-IV*) as an example of an eating disorder not otherwise specified. A number of controlled studies have examined the efficacy of cognitive-behavioral therapy in this patient group and have found that it is a beneficial therapeutic approach in the reduction of binge-eating episodes (Agras et al. 1997; Marcus, Wing, and Fairburn 1995; Peterson et al. 1998). Frequently a group format is used in treating obese patients. Therapists need to modify the CBT treatment when working with patients with binge-eating disorder. Such patients tend to gain weight during CBT treatment; to prevent this, some weight-control measures, along with a mild exercise program, need to be incorporated into the first phase of treatment and is monitored throughout the course of therapy (Agras and Apple 1997). Second, while the bulimic patient's main goal is to stop binge eating, the obese patient primarily enters treatment to lose weight. Thus the therapist must emphasize that the primary goal is the cessation of binge eating and establishing a healthier eating style. Further, the patient must understand that more important than reaching any goal weight is the need to develop control over binge eating in order to diminish the feeling of being out of control and reduce a preoccupation with food. Not all obese patients are able to conceptualize the importance of working toward a different attitude while not losing weight.

COGNITIVE-BEHAVIORAL THERAPY AND ANOREXIA NERVOSA

Many psychological characteristics are common to both anorexia and bulimia nervosa. These include weight preoccupation, perfectionistic tendencies, starvation symptoms, and faulty cognitive patterns. Presumably, then, CBT should also be an effective treatment for anorexia nervosa. A number of early reports (e.g., Garner and Bemis 1982) had suggested that CBT might be an effective treatment for anorexia nervosa. However, Cooper and Fairburn (1984), while reporting some success with anorexics who binged and purged, found that the restricting subtype fared poorly with CBT. These early reports were anecdotal clinical case studies that lacked the methodological rigor of controlled clinical trials. One reason for a dearth of research in this area could be that the incidence of anorexia nervosa is quite low, making it more difficult to gather a cohort large enough to undergo statistical analysis. Another issue lies in the fact that the treatment of choice for the extreme low-weight anorexic is typically hospitalization. Thus a therapeutic program devised for outpatients would have to preclude the more chronic anorexic patient and would affect the generalizability of the results across the symptom severity continuum.

Recently attempts have been made to describe a CBT treatment approach for anorexic patients (Garner, Vitousek, and Pike 1997), and clinical trials are presently under way to evaluate the efficacy of CBT in anorexia nervosa.

Two major issues complicate CBT treatment in anorexic patients that are absent in bulimia nervosa. These include the level of motivation for therapeutic help and addressing the issue of weight and weight gain in treatment (Garner, Vitousek, and Pike 1997). Although motivating eating disorder patients can be problematic, it is especially arduous with the anorexic. The vast majority of anorexic patients will resist gaining weight, though this is the main goal of treatment for them. Thus the initial phase of CBT must incorporate a substantial amount of time devoted to developing and sustaining motivation for change.

In CBT, the bulimic patient is reassured that weight gain, if any,

would be minimal, thus reducing the fear of becoming fat. However, since the major goal in treating the anorexic is to gain weight, the patient must deal with the fear of becoming fat while actually becoming fatter (Garner, Vitousek, and Pike 1997). This issue can and does have a devastating effect on motivational levels and may prompt the patient to terminate treatment prematurely. The therapist must constantly address this concern, as it can quickly sabotage the therapy.

The bulimic patient is entrusted with the task of self-weighing on a weekly basis. However, the anorexic must be regularly checked by the therapist or nutritionist, so that weight goals are carefully monitored.

Although the bulimic patient is introduced to the concept of self-monitoring at the first session, the anorexic needs to be gradually exposed to this therapeutic task. This is because initially the anorexic is disinterested in progress, since that requires gaining weight. Further, the anorexic may require meal planning in order to structure her food intake.

The social dysfunction that often accompanies anorexia nervosa, the frequent need for family involvement, particularly with young anorexic patients, and a longer duration of therapy (the anorexic patient may remain in CBT treatment for one to two years), have contributed to an interweaving of cognitive-behavioral and interpersonal approaches in working with this patient population (Garner, Vitousek, and Pike 1997). (See chapter 11 for examples of interweaving approaches.)

Other treatment differences between the anorexic and bulimic patient include a focus on the medical risks and the psychobiology of starvation associated with anorexia nervosa during the educative aspects of CBT. In addition, the longer treatment duration is required because of motivational issues. However, the bulimic patient is also at risk (see chapter 1 above). Both anorexic and bulimic patients require ongoing medical evaluation and surveillance as part of the treatment plan. Typically sessions are scheduled twice weekly for Stage 1 of treatment (the first month), whereas Stage 2 has weekly sessions that can last for as long as a year. Stage 3 usually lasts six months, at which time the frequency of appointments is first biweekly and then monthly.

INTERPERSONAL PSYCHOTHERAPY AND EATING DISORDERS

Like cognitive-behavioral therapy, interpersonal psychotherapy (IPT) was initially developed for the treatment of nonpsychotic depression in an outpatient setting (Klerman et al. 1984). The major underlying assumption of IPT is that the development of clinical depression occurs in a social and interpersonal context and that the onset, response to treatment, and outcome are influenced by the interpersonal relations between the depressed patient and significant others (Klerman and Weissman 1993). These authors stress that there is no assumption that interpersonal difficulties cause depression but rather that the depression occurs within an interpersonal context. The therapeutic strategies of IPT are designed to assist the patient in dealing more effectively with interpersonal dysfunction.

Four interpersonal problem areas have been identified. The most common difficulties are role disputes and are typically seen in married couples. Role transition is another area and often takes the form of problems resulting from separating from parents and adjusting to life away from home or difficulty adjusting to marriage or parenthood. Unresolved grief is another interpersonal conflict area. Interpersonal deficits, characterized by an inability to form or maintain intimate relationships (often seen in schizoid individuals) is the fourth conflict area.

Fairburn (1993) adapted IPT for the treatment of bulimia nervosa. The only modifications included an assessment of the eating disorder in the first stage of treatment and a limitation to a total of nineteen sessions. It is interesting to note that after the eating disorder was discussed in the initial sessions (and the discussion centers on the relationship between interpersonal events and the bulimic behavior), it was essentially ignored throughout the remainder of therapy, and the focus of treatment concerned the interpersonal realm. Fairburn and colleagues (1991) found that at one-year follow-up, IPT was as successful a treatment for bulimia nervosa as was CBT. This finding was also replicated in a study of binge-eating disorder using IPT and CBT in a group treatment setting (Wilfrey et

al. 1993). These results clearly demonstrate how profound an impact interpersonal dysfunction has on the maintenance of these disorders. It is also noteworthy that the onset of many eating disorders is often during adolescence, a developmental period in an individual's life heavily laden with issues surrounding interpersonal relationships. Thus it is not surprising that IPT is an effective treatment format for binge-eating disorders, since it addresses some underlying interpersonal issues that might have contributed to the development of eating problems.

OTHER SHORT-TERM PSYCHOLOGICAL TREATMENTS

Another treatment approach used for bulimia nervosa is response prevention (Leitenberg et al. 1988), a behavior therapy that has its roots in flooding and implosion techniques. In this treatment the patient binges during the course of a therapy session until the desire to purge occurs. The patient then remains in session until that urge dissipates, demonstrating that control over purging can occur. The underlying assumption is that once the patient's desire to purge has been eliminated, binge-eating episodes will be reduced. While the initial study showed some promise in the technique (although patients found the procedure quite disturbing), later work (Agras et al. 1989) demonstrated that adding response prevention to CBT led to poorer results than when CBT was used alone.

Another therapeutic approach used with binge-eating disorders is psychoeducational group therapy. This modality is primarily a stripped-down version of CBT, since it only includes the psychoeducational aspects. In a group format, patients receive education in the areas of nutrition, the adverse effects of dieting, bingeing and purging, and sometimes include discussion on the cognitive distortions that frequently occur in eating disorder patients. It is usually a very brief intervention (up to five sessions) and has shown some success (see Olmstead et al. 1991) in patients with mild binge-eating disturbances.

Self-help manuals, using a CBT approach to binge eating difficulties, have also been developed. This format sometimes includes a therapist-led discussion on the use of the manual. Other versions

have no guided assistance. In the initial study, Cooper, Coker, and Fleming (1994) showed that more than half the bulimic patients reported marked clinical improvement using a therapist-led, self-help manual.

With the advent of managed health care, impetus has developed in our field to identify the most cost-effective and easily disseminated forms of treatment. Fairburn and Peveler (1990) have suggested the adoption of a stepped-care approach in the treatment of binge-eating disorders. This health care delivery model involves first offering a simple treatment, since some patients will respond positively. The first treatment tier might be an unsupervised self-help format. Those who do not respond move on to the next step, which involves more intensive therapy. For example, it might consist of a guided self-help treatment. Should self-help prove unsuccessful, then the third level of care, such as a CBT approach, would be required. If the patient proves to be a nonresponder, then another level of treatment would be instituted, such as the addition of an antidepressant, partial hospitalization, or an inpatient stay. Recent research has shown that this model may be promising for both bulimia nervosa (Davis et al. 1999) and binge-eating disorders (Peterson et al. 1998). Of particular importance at this juncture, however, is for researchers to identify patient characteristics that may predict the level of stepped-up care to which the individual will respond.

CONCLUDING REMARKS

The efficacy of cognitive-behavioral therapy and interpersonal psychotherapy has been clearly demonstrated in the treatment of binge-eating disorders. Furthermore, initial clinical studies have been encouraging for the use of CBT in treating anorexia nervosa as well, and controlled clinical trials are currently under way.

Since cognitive-behavioral therapy and interpersonal psychotherapy are both manualized treatments, they have the added advantage of being widely available to clinicians and easier for experienced therapists to acquire the skills needed to use these approaches. Moreover, since these approaches are highly structured

and have time limits, both clinician and patient are forced to remain focused on a circumscribed set of symptoms and behaviors, and to work hard on making well-defined changes. All these features are especially attractive given the reality of managed care and the corresponding need for adequate and effective treatment within that circumscribed framework.

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