THEMATIC CONSIDERATIONS IN THE TREATMENT OF ANOREXIA NERVOSA

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ABSTRACT

The purpose of this study is to explore four important questions. The first is, "What are common themes that arise in the literature with regard to the etiology of Anorexia Nervosa (AN)?" The second is, "What role might family dynamics play in the development of AN in adolescents?" The third is, "What role might family dynamics play in the treatment and recovery process of AN in adolescents?" The fourth and final question is, "What role might spirituality play in the treatment and recovery process of AN in adolescents."

In order to answer these important questions, I have reviewed pertinent literature in the hope of discovering common themes that will provide insight into both the etiology, or contributing factors to the development of AN, as well as its effective treatment. The results of this review suggest a strong correlation between AN in adolescents and family dynamics with regard to etiology and effective treatment. There are no definitive conclusions however that can be made with regard to root causes and predictability of this illness for a variety of reasons. With regard to the role of spirituality in the treatment and recovery process, there seems to be an extreme deficiency in studies exploring how spirituality may be an effective tool in countering the irrational thoughts and behaviors that are common among adolescents suffering from anorexia.

METHOD

DATABASES USED FOR RELEVANT SOURCES:
- PsychINFO
- ERIC

KEY WORDS USED IN DATABASE SEARCH:
- Anorexia Nervosa
- Etiology
- Family
- Effective Treatment
- Spirituality
- Religiosity

LIMITS
- 2000 and later only
- Peer Reviewed, Scholarly Journal Articles only
- English language only

SEARCH RESULTS
- PsychINFO proved to be the database with best results
- Qualitative and Qualitative studies were used in this study

INTRODUCTION

Anorexia Nervosa (AN) is an illness that primarily affects females. It is estimated that 8 million people suffer from AN (Elliott, 2010). Ninety percent of these cases involve females, most of whom are adolescents. This illness is characterized by three important criterion that must be met for diagnosis of AN. The first is significantly low body weight, which could be defined for adolescents as "less than minimally expected" (American Psychiatric Association, 2013). The second is an intense fear of gaining weight, accompanied by behavior that purposefully inhibits weight gain. The third is disruptions in body image, or how one experiences their body weight and shape. This kind of disruption influences one's self-perception and evaluation, and is often accompanied by a lack of recognition of the seriousness of the illness (American Psychiatric Association, 2013).

There are two primary presenting types of individuals with AN. The first is the restrictive type. These individuals attempt to inhibit weight loss "primarily through dieting, fasting and, or excessive exercise" (American Psychiatric Association, 2013). The second is the binge eating type. These individuals inhibit weight gain primarily through self-induced vomiting, also known as "purging," or "the misuse of laxatives, diuretics or enemas" (American Psychiatric Association, 2013).

There are several common behaviors among adolescents with AN in addition to dieting, purging and excessive exercise. The first is frequent weighing. The second is obsessive measuring of body parts. The third and final behavior is what is known as "body checking" (American Psychiatric Association, 2013). Behaviors like these have caused many to compare similar behaviors common within obsessive compulsive disorder (OCD) (Breithaupt, 2014, p. 591). All of these suggest an unhealthy preoccupation with physical appearance.

Typically, individuals with AN view weight loss as an achievement of which to be proud. They also can view weight loss as an extraordinary feat of self-discipline. On the other hand, weight gain is viewed as an "unacceptable failure of self control" (American Psychiatric Association, 2013). Timothy D. Walsh, M.D. (2013) correctly observes that AN "occurs primarily in cultures where food is plentiful and where, for some reason, special value is attached to dieting and weight loss" (Walsh, 2014, p. 477). He later observes that, "In current Western culture, successful weight loss is an often wished for, and encouraged goal that is rarely achieved" (Walsh, 2013, p. 479). Thus, dieting behavior in individuals is reinforced. He suggests that the motivation behind such behavior is to "cope with negative affect," along with regaining a sense of pride, power, control and accomplishment (Walsh, 2013, p. 479).

Anorexia Nervosa negatively affects individuals physiologically, psychologically, cognitively and relationally. Physiologically, gradual starvation and purging behaviors can be life threatening in several ways. According to the DSM-5, "The nutritional compromise associated with this disorder affects most major organ systems and can produce a variety of disturbances." Amenorrhea, vital sign abnormalities, and loss of bone mineral density are common (American Psychiatric Association, 2013). Psychologically, many with AN, and who are malnourished, exhibit depressive symptoms. Common among these symptoms are "depressed moods, social withdrawal, irritability, insomnia and diminished interest in sex" (American Psychiatric Association, 2013). Cognitively, "obsessive compulsive tendencies related and unrelated to food are often prominent." Additionally, individuals with AN may be "concerned about eating in public, feelings of ineffectiveness, a strong desire to control their environment, inflexible thinking, limited social spontaneity and overly restrained emotional expression" (American Psychiatric Association, 2013).

Among other psychiatric illnesses, AN has the highest mortality rate due to suicide and "secondary complications resulting form malnutrition." In 1995, Litt reported that the mortality rate among those with AN was, "In excess of 10%." Additionally, a study performed by Harris in 1997 found that the risk of suicide among patients diagnosed with AN to be "increased 23 times" (Manley, 2003, p. 33).

There are several common increased risk factors for the development of AN that are significant. They are being female, being an adolescent, and having obsessional tendencies (Walsh, 2013, p. 477). In addition to these, J. Carol Elliott, PhD, includes "family dynamics and relationships" as a measure of increased risk (Elliott, 2010, p. 37).

These realities demonstrate the seriousness and dangers inherent to adolescents who develop AN. Many have attempted to understand the etiology of AN in order to discover either predictive and preventative measures to be taken, or in order to develop treatment solutions that are predictive of full recovery. Definitive answers to these important questions remain illusive, and so the following study is presented to you in the continued pursuit of insight and understanding of the development and effective treatment of AN in adolescents.

RESULTS

I. THE ETIOLOGY OF ANOREXIA NERVOSA IN ADOLESCENTS IS MULTI DIMENSIONAL

A. COGNITIVE
- AN in adolescents is developed and maintained by automatic thoughts and dysfunctional assumptions (Damiano, 2014).
- Unmet human needs cause individuals to develop "maladaptive schemas" in order to cope with these deficiencies (Damiano, 2014).
- Body image disturbances contribute to the development and maintenance of AN in adolescents (Hartmann, 2014).
- Rigid and obsessive thoughts experienced by anorectics resemble presenting symptoms of OCD (Breithaupt, 2014).

B. AFFECTIVE
- Anorectics typically have difficulty distinguishing feelings from physical symptoms, describing feelings to others and experience diminution of imagination and externally oriented thinking (Torres, 2014).
- Anorectics commonly experience profound "psychic pain" and a sense of anguish and despair which can sometimes lead to suicidal ideation, self mutilation, suicidal gestures and or attempts (Manley, 2013).
- Anorectics regularly feel undeserving of help, helpless, hopeless, difficulty in expressing feelings and ambivalence toward treatment (Manley, 2013).
- Anorectics experience fear toward and mistrust of healthcare providers are attempting to steal away a coping mechanism they perceive as necessary (Manley, 2013).

C. BEHAVIORAL
- The most common behaviors among anorectics are dieting and excessive exercise (Hartmann, 2014).
- A combination of conditioned reinforcement, stimulus response learning and operant conditioning contributes to the development and maintenance of AN in adolescents (Walsh, 2013).
- Dieting becomes rewarding all by itself (Walsh, 2013).
- The behaviors common among anorectics are therefore highly resistant to change (Walsh, 2013).

D. FAMILY DYNAMICS
- The belief that unhealthy family dynamics contributes to the development and maintenance of AN in adolescents has been promulgated for many years by people like Lasegue, Gull and Minuchin (LeGrange, Eisler, 2008).
- Most significantly Minuchin believed that the aim of therapy is to "change the way a family functions" (LeGrange, Eisler, 2008).
- There is a strong amount of evidence to support this claim (Elliott, 2008):
  - Crisp, Hsu, Harding, and Hatshorn, 1980
  - Sours, 1980
  - Humphrey, 1989
  - Weir, 1994
  - Bugola, 1995
  - Parente, 1998
  - Fitzgerald and Lane, 2000
  - Ward, Ramsay, Turnbull, and Treasure, 2000
- Greg Dring (2015) concludes in his study that family factors are "likely to account for the development of AN in adolescents" and that, "A family model is need that accommodates a variety of factors that may contribute to developmental pathways that culminate in the development of AN in adolescents" (Dring, 2015, p. 88).

E. SPIRITUALITY
- Surprisingly spirituality can be counted among the manifold etiological factors contributing to the development of AN in adolescents (Marsden, et al., 2007).
- Marsden (2007) highlights religious asceticism as a religious justification for anorectic behavior. She cites a recent study that found that religious justifications for AN were common among women in Ghana (Marsden, et al.2007).
- In a second level, qualitative study of ten women Marsden (2007) observed five important themes (Marsden, et al., 2007):
  - **Control** - Issues of familial and religious control
  - **Self image** - Recurring themes of "shame, guilt and self hatred" suggesting a view of God as being authoritarian and harsh
  - **Sacrifice** - "Making up for imagined wrong doing"
  - **Salvation** - God offers recovery from AN, and rescue from death.
  - **Maturation** - All participants began the study believing starvation was "God's will. Some came to see that AN itself was displeasing to God.

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RESULTS

2. FAMILY DYNAMICS AND THE EFFECTIVE TREATMENT OF ANOREXIA NERVOSA IN ADOLESCENTS

A. LEGRANGE AND EISLER, 2008

- "Family therapy has gradually established itself as an important treatment approach for adolescent AN, and is supported by growing empiric evidence of its efficacy" (p. 160).
- In their study, LeGrange and Eisler (2008) found that between 50% and 70% of adolescents are weight restored by the end of treatment.
- Additionally, if the family treatments studied were taken together, "At a 4 to 5 year follow-up 60% to 90% had fully recovered.

B. CIAO ET AL. 2014

- A comparison between Family Based Therapy (FBT) and Adolescent Focused Therapy (AFT) found that several aspects of family functioning are associated with full remission of AN.
- They are affective involvement, behavior control and general functioning (Ciao, et al., 2014).

C. VORIADAKI ET AL. 2015

- Cites strong evidence in support of FBT
  - Eisler et al., 1997, 2000 and 2007
  - Le Grange et al., 1992
  - Lock et al., 2005,2006 and 2010
  - Robin et al., 1999
  - Russell et al., 1987
- Demonstrated the effectiveness of yet another family treatment option called Multi-Family Therapy (MFT)
  - Five out of five adolescents found it to be a positive experience
  - Nine out of ten parents found it to be a positive experience

D. PATEL ET AL. 2003

- Family therapy is effective in essence because of the following
  - Provides a means for stronger and healthier family relationships.
  - Enables families to understand their relationships
  - Offers a source of emotional support
- This study found that outcomes at a one year follow up were better for adolescents who received family therapy versus those who received individual therapy.

E. SMITH, COOKE-COTTONE. 2011

- Cites a study by LeGrange in 2005 examining 45 patients with a mean age of 14.5 who all received FBT
  - 56% of patients obtained a body mass index (BMI) within normal limits and regular menses.
- Cites another study by Wallin and Kronwall in 2002 exploring changes in family dynamics among seventeen families after a course of FBT at a two year follow up
  - 65.4% of patients were in recovery
  - 26.9% were much improved or improved

3. SPIRITUALITY AND THE EFFECTIVE TREATMENT OF ANOREXIA NERVOSA IN ADOLESCENTS

A. MANLEY, 2003

- States, "A focus on spirituality may be very life affirming for the adolescent and enable her to recognize that suicide is not a value that is a part of her own ethical framework" (Manley, 2003, p. 38).
- This is an important statement due to the tendency of suicidal ideation common among adolescents with AN.

A. SMITH ET AL., 2003

- Cites six important studies which are evidence of spirituality playing a role in a young woman's recovery from AN
  - Hsu, Crisp and Callender, 1992
  - Garrett, 1996
  - Mitchell et al., 1992
  - Rorty, Yager, Rossotto, 1993
  - Williams-Biddult, 1996
- Building upon this evidence, Smith et al. (2003) found a significant positive relationship between gains in spiritual well being and other positive treatment outcomes.
- Women who grew in spiritual well bing tended to develop the following
  - Healthier attitudes toward eating
  - Improvement of impression of body image
  - Psychological symptoms declined
  - Less conflict reported in interpersonal relationships
  - Improved social role performance

DISCUSSION

The etiology of AN in adolescents is very complex and self evidently multi-dimensional. The results of this study demonstrate that reality poignantly. The etiological findings however provide insight into this development of this disease, and inform treatment practices. The body of literature regarding the etiology and effective treatment of AN in adolescents is strong in that there are a great many studies that are relevant, important and that can be generalized to larger populations. It is therefore significant that dysfunctional family dynamics were shown to be among the more significant and potential etiological explanations for both the development and maintenance of AN in adolescents. It is most significant that regardless of etiology, improving family dynamics is a necessary and important goal in the effective treatment of AN in adolescents. This research demonstrates that treatments that have the core goal of improving family dynamics are among the most effective in helping adolescents fully recover.

The deficiency in research regarding the role spirituality in the treatment and recovery process is glaringly apparent. What is more, the articles included in this study are important, but are somewhat weak in that the small populations studied cannot be generalized to larger populations. More research needs to be performed in order to demonstrate how common spiritual concepts, across the religious and denominational spectrum, interact with the automatic thoughts, maladaptive schemas, obsessive behaviors and broad range of emotions that are experienced by individuals with AN. In other words, what are the specific alternatives that spirituality and religiosity offer to anorectics, and will they be predictably effective in the treatment and recovery process?

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