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# Anorexia Nervosa

Focal Psychodynamic  
Psychotherapy

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# Anorexia Nervosa

Focal Psychodynamic Psychotherapy

**Hans-Christoph Friederich, Beate Wild,  
Stephan Zipfel, Henning Schauenburg,  
and Wolfgang Herzog**

In collaboration with Sandra Schild and Miriam Komo-Lang



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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  
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## Reference

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

Hans-Christoph Friederich  
Beate Wild  
Stephan Zipfel  
Henning Schauenburg  
Wolfgang Herzog



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# 1 Description of the Disorder

## 1.1 Description

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 eating disorder anorexia nervosa was first described in 1873**

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

Health Association (WHO, 1992) and of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) of the American Psychiatric Association (APA, 2013), with a few exceptions, show agreement regarding the disorder of the disease anorexia nervosa (see Table 1). A stable version of the 11th revision of the ICD was released on June 18, 2018 for the implementation phase (WHO, 2018). The final version is due to be released in 2022.

**Table 1**  
**Diagnostic criteria for anorexia nervosa according to the ICD-10 and DSM-5**

DSM-5	ICD-10 (F50.0)
A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. <i>Significantly low weight</i> is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.	A. Body weight is maintained at least 15% below that expected (either lost or never achieved), or Quetelet's body-mass index (= weight (kg) to be used for age 16 or more) is 17.5 or less. Prepubertal patients may show failure to make the expected weight gain during the period of growth.
B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.	B. The weight loss is self-induced by avoidance of "fattening foods". One or more of the following may also be present: <ul style="list-style-type: none"> <li>• self-induced vomiting;</li> <li>• self-induced purging;</li> <li>• excessive exercise;</li> <li>• use of appetite suppressants and/or diuretics.</li> </ul>
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	C. There is body-image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.

**Table 1 (continued)**

DSM-5	ICD-10 (F50.0)
<p><b>Coding note:</b> The ICD-9-CM code for anorexia nervosa is <b>307.1</b>, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).</p> <p><i>Specify</i> whether:</p> <p><b>(F50.01) Restricting type:</b> During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.</p>	<p>D. A widespread endocrine disorder involving the hypothalamic – pituitary – gonadal axis is manifest in women as amenorrhoea and in men as a loss of sexual interest and potency. (An apparent exception is the persistence of vaginal bleeds in anorexic women who are receiving replacement hormonal therapy, most commonly taken as a contraceptive pill.) There may also be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion.</p> <p>E. If onset is prepubertal, the sequence of pubertal events is delayed or even arrested (growth ceases; in girls the breasts do not develop and there is a primary amenorrhoea; in boys the genitals remain juvenile). With recovery, puberty is often completed normally, but the menarche is late.</p>