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COGNITIVE-BEHAVIORAL PSYCHOTHERAPY OF PSYCHOLOGICAL BULIMIA: THEORY, METHOD, EMPIRICAL STATUS AND FUTURE DIRECTIONS OF DEVELOPMENT

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Summary

Despite the development of ways to help patients diagnosed with bulimia nervosa, its treatment continues to be a therapeutic challenge. The first method of choice in the treatment of bulimia nervosa is cognitive-behavioral therapy because of its effectiveness, demonstrated in randomized studies. Nevertheless, a large proportion of patients are not covered by this method, which may be related to the insufficient number of clinicians using it. The aim of this article is to present the current knowledge on cognitive-behavioral therapy of bulimia (CBT-BN): its theoretical basis, development history, description of the method and its empirical status and options for increasing the effectiveness of treatment. The development of CBT-BN has contributed to the emergence of enhanced cognitive-behavioral therapy (CBT-E). The following part of the article describes the theoretical basis of CBT-BN. Next, CBT-E is characterized – its application, stages of therapy as well as the results of tests verifying the theoretical basis and the effectiveness of the therapy are described. The last part of the work concerns the possibilities of increasing the effectiveness of CBT-BN, including integration with other methods of helping, for example, motivational dialogue ("Motivational Interviewing", MI). In this context, it seems promising to use new forms of cognitive-behavioral therapy, referred to as the third wave of cognitive-behavioral therapy: dialectic behavioral therapy (DBT), integrative cognitive-affective therapy (ICAT), schema therapy (ST).

Introduction

Bulimia nervosa is considered difficult to treat due to the low level of motivation to change, withdrawal of patients from the therapy [1], the persistence of symptoms despite treatment, relapses [2, 3] and the coexistence of other psychiatric disorders [4]. The illness is also related to limitations of psychosocial functioning, increased mortality risk, and high costs of treatment in the healthcare system [5]. These factors make it a problem that requires clinicians' interest and continuous improvement of ways to help this group of patients.

The first method of choice in the treatment of bulimia nervosa is cognitive-behavioral therapy, because of the best documented research effectiveness [6]. However, clinical and research experience shows that a too small group of patients is covered by this form of therapy [7]. Therefore, it is important to disseminate knowledge about the applications of cognitive-behavioral therapy among clinicians and patients suffering from bulimia nervosa [13].

The aim of this article is to present current knowledge on the cognitive-behavioral therapy of bulimia (CBT-BN). Starting from the presentation of its theoretical bases, and development history, followed by a brief description of the method and review of the tests verifying its effectiveness. The final part of this paper concerns the possibility of increasing the effectiveness of treating bulimia nervosa by developing CBT-BN or using the third wave of cognitive-behavioral therapy.

Theoretical bases and method's development

Beck's classical cognitive model emphasizes the role of cognitive processes in explaining human functioning and causes of disorders. According to this concept, emotions and behaviors are the results of how events are interpreted, Thought patterns are acquired in the learning process. Their change is possible and requires to be based on the same process. Based on cognitive restructuring techniques, it is possible to change dysfunctional interpretations, i.e. a change in the area of emotions and behaviors which might be disadaptive [8].

According to the hypothesis of cognitive specificity in mental disorders, characteristic cognitive schemas can be distinguished [9]. Thanks to this, it is possible to create specific models of mental disorders that form the basis for therapy planning. According to Fairburn [10], bulimia nervosa is mainly a cognitive disorder, because patients have cognitive distortions in beliefs about the importance of appearance and weight, as well as their perception of self-esteem. A dysfunctional scheme of low self-esteem causes dependence of their own value on shape, weight and their control [12]. Therefore, one of the main goals of the therapy is to restructure thoughts and beliefs regarding excessive concentration on figure and weight and to build self-esteem based on other spheres of life.

CBT-BN has been developing since the 1970s and in the process of time, this method has been improved, amongst others by Fairburn, a world-class researcher in the field of eating disorders [12]. As a result, enhanced cognitive-behavioral therapy ("Cognitive Behavioral Therapy-Enhanced", CBT-E) was created. Currently, it is the dominant approach in the treatment of bulimia.

The basis for CBT-BN is the cognitive-behavioral theory of bulimia maintenance, which describes the specific features of this disorder: low self-esteem, excessive concentration on weight and figure and their control, dietary restrictions, binge eating and compensatory behaviors [10]. The dysfunctional self-esteem schema is the core psychopathology. Patients try to compensate their low self-esteem by excessive concentration on their figure and weight and the ability to control them. The other clinical features of bulimia are secondary to these

mechanisms. The only exception is binge eating, which does not result directly from the main psychopathology but is the result of restrictions in eating. Introducing a strict diet and other behaviors aimed at weight control results in the occurrence of binge eating, which has a negative impact by increasing fears about the figure and weight. Then, there are attempts to strengthen control in the nutrition area by intensifying diet restrictions, which again increases the possibility of binge eating. In order to avoid weight gain, patients use compensatory strategies (eg, vomiting, using laxatives), which they believe may prevent it. In this way, a pattern of the typical bulimia behavior develops, consisting of interchanging a rigorous diet with binge eating and purgation [12].

Unpleasant events and emotions associated with them can also lead to binge eating. True-life situations can cause negative reactions, including unpleasant emotions that increase the risk of binge eating. This is because in such moments it is particularly difficult for these patients to persevere in limiting food. In addition, the function of binges is the distraction from a difficult situation and soothing negative emotions.

The lack of reaction of some patients to CBT-BN motivated Fairburn and colleagues [12] to improve the existing cognitive-behavioral theory on which CBT-E is based. This model describes four additional mechanisms that maintain the disorder: low self-esteem, mood intolerance, perfectionism, and interpersonal problems. For some patients, they play a significant role because they can prevent effective treatment. Therefore, two versions of CBT-E were created: "focused" (CBT-Ef) and "broad" (CBT-Eb). The first one is the basic version of the therapy, focused on the specific psychopathology for eating disorders. With time, the module concerning mood intolerance was included in the CBT-Ef. By contrast, CBT-Eb includes additional maintaining mechanisms: pervasive low self-esteem, clinical perfectionism, and interpersonal problems. The indication for its use is the occurrence of more complex psychopathology of the patient. Another change introduced by Fairburn and colleagues [12] is the extension of the cognitive-behavioral theory of maintaining bulimia to other eating disorders. The transdiagnostic perspective introduces an innovative way of understanding and treating eating disorders. As a result, CBT-E can be used to treat various eating disorders.

Bulimia therapy: method's description, techniques, applications

As Fairburn emphasizes [10], cognitive factors are crucial for eating disorders, including the core of psychopathology, which is excessive concentration on weight and figure and their controlling. Therefore, interventions used in CBT-E are partly based on classical techniques of cognitive-behavioral therapy, originally developed for people suffering from depression [8].

Patients learn cognitive and behavioral techniques aimed at reducing dietary restrictions and preventing binge eating. They acquire the ability to identify and change their dysfunctional thoughts and beliefs about weight, figure, and eating.

The key to planning the therapy is conceptualization, which is based on the cognitive model of a specific disorder, considering the patient's early experience and its impact on core beliefs and current problems, along with the given meaning [11]. Also in CBT-E, the treatment strategy is based on individual conceptualization [12]. During treatment, it is not necessary to deal with all symptoms but only those which are the most important maintaining processes (e.g. excessive concentration on weight and appearance, compensatory behaviors). In the psychopathology of bulimia nervosa, the secondary symptoms, from the conceptualization point of view, may lapse if the main maintaining mechanisms are no longer active [10].

Treatment is limited in time and adapted to different conditions [10]. In case of outpatients, the therapy may last 20 weeks (20 sessions) or 40 weeks (40 sessions) if the BMI is lower than 17.5. In both cases, sessions are initially scheduled twice a week. CBT-E is adapted for adults and adolescents, it can be implemented in inpatient and outpatient care, and in individual or group versions.

The main goal of CBT-E is to distance the patient from the existing disorder and its symptoms. The therapy includes normalizing eating habits, introducing planning and regular meals, learning cognitive-behavioral techniques to cope with situations that can trigger binge eating and vomiting, modifying dysfunctional beliefs about the importance of eating, weight, and shape, building self-esteem based on other spheres of life, and prevention of relapses [10].

CBT-E consists of four stages. The first of them includes establishing a supportive relationship and the patient's involvement in the therapy, psychoeducation (about body weight and its regulation, somatic effects of symptoms, ineffectiveness of binge eating and compensatory behaviors), and cooperative creation of a cognitive model of maintaining bulimia. It is also crucial to introduce two procedures: weighing during the session and regular eating. The introduction of these procedures is the basis for further steps in the therapy.

The second stage of CBT-E concerns a detailed summary of the changes obtained and the detection of factors that can block the progress. It is also the time to analyze the conceptualization and, if necessary, modify it and consider the implementation of the "extended" version of the therapy. Finally, an individualized plan of the next stage of therapy is created.

The third stage is the main part of the therapy. The therapist focuses on the modification of bulimia-specific psychopathologies: overestimation of the significance of shape and weight,

excessive focus on controlling nutrition, dietary restraints, underweight, rigorous diet, changes in eating caused by external events or mood changes. Depending on the patient's individual conceptualization, additional modules can be used, focused on low self-esteem, perfectionism, or interpersonal problems.

The last stage of treatment focuses on the summary of the effects of the whole therapy, the development of a plan for maintaining the changes and preventing relapses.

Empirical verification of the theory and the effectiveness of the therapy

A characteristic feature of cognitive-behavioral therapy is that this method is continuously being verified in research. By now, over 50 randomized research trials with controlled groups have been conducted, the results of which are fairly consistent and show better effects of cognitive-behavioral therapy than other psychotherapeutic methods [13].

Indirect evidence in favor of the cognitive model of bulimia comes from studies examining the cognitive functioning of patients. The characteristic of this group is focusing on topics related to food, weight [14], and figure [15], which is the central element in the psychopathology of eating disorders. Two studies have shown the relationship between over-evaluation of weight and shape, dietary restraint, and binge eating [16, 17].

The hypothesis about the influence of cognitive disturbances on maintaining bulimia symptoms was also tested in experimental studies. Cooper and colleagues [18] showed that cognitive disturbances, especially excessive concentration on eating, weight, and shape, can contribute to maintaining the symptoms of bulimia.

Another confirmation of the cognitive concept of bulimia is provided by research on the effects of therapy. A series of studies on cognitive-behavioral therapy showed that it is effective for patients suffering from bulimia, and about half of the patients have remission of symptoms that persists after the end of treatment [19-21]. Further evidence for the theory was obtained by comparing the effectiveness of cognitive-behavioral bulimia therapy with its version devoid of procedures aimed at cognitive change (behavioral therapy). It turned out that the latter increases the probability of relapse [22], in addition, about half of the patients give up treatment prematurely and the effects of therapy are weaker [19, 23] because it does not affect the excessive concentration on weight and figure.

The relationship between the severity of concerns about weight and appearance and the risk of relapse was also checked. Fairburn and colleagues [19] presented results showing that the greatest probability of recurrence was in the group of patients with the highest level of residual weight and shape concerns. In the group of people with the highest level of anxiety

about weight and shape, 75% experienced a relapse of bulimia, and in the group with the least anxiety only 9%.

Evidence for the confirmation of the cognitive model also stems from reports from studies of mediators of bulimia therapy effects. Early interventions aimed at reducing dietary restraints were a mediator of therapy effects, measured by the number of binge eating and vomiting [24]. Similar results were obtained in a group of patients with bulimia, treated only with behavioral therapy [23]: the reduction of dietary restraints contributed to the reduction of symptoms. However, a prospective study of untreated bulimia showed that the initial level of over-concentration on weight and shape made it possible to predict the persistence of binge eating. The association of excessive concentration with symptoms of bulimia was partially mediated by the intensification of dietary restraints. The second predictor of binge eating was obesity in the time of childhood. According to cognitive theory, this factor can sensitize a person to issues related to shape and weight, leading to continuous restrictions in food intake and, as a result, intensifying the risk of binge eating. The results of the study also showed that the persistence of binge eating was a predictor of compensatory behavior maintenance. Both these behaviors reinforce each other, which is one of the basic assumptions of the cognitive model [25].

There have also been reports regarding the relationship between low self-esteem and excessive concentration on weight and shape of people suffering from bulimia [16]. Preliminary studies investigating the influence of self-esteem on the result of the therapy have shown that the lower the self-esteem at the beginning of therapy, the smaller the effectiveness of bulimia treatment [19, 26]. However, not all studies show such trends, probably due to a more complex relationship between variables [27].

In a cross-sectional study, the assumptions of the cognitive-behavioral model of bulimia were checked and could be confirmed in most cases. Predictors of binge eating and purging were: low self-esteem, excessive concentration on appearance and weight, and dietary restraints. Contrary to the hypothesis, a high level of dietary restraints did not allow for a prediction of increased binge eating, which might be explained by the use of specific measurement tools [28].

The described results of empirical investigations form the basis for planning therapeutic procedures. In addition to the normalization of eating habits, also the remaining maintaining mechanisms of the disorder should be the subject of bulimia treatment, i.e. low self-esteem, dietary restraints, excessive concentration on weight and shape [10].

As the cognitive-behavioral theory of bulimia developed, an enhanced version (CBT-E) was created, which also has been proved to be an effective method of treating patients suffering from eating disorders, including people with bulimia [20]. In addition, in this study, the effectiveness of the two CBT-E versions, "focused" (CBT-Ef) and "broad" (CBT-Eb) was compared. CBT-Ef was more effective than CBT-Eb for patients with less complex psychopathology and the opposite was true for the group of patients with more complex psychopathology (serious or moderate intensity of at least two mechanisms among: mood intolerance, perfectionism, low self-esteem, and interpersonal difficulties).

The effectiveness of CBT-BN was also compared with pharmacotherapy and other therapeutic methods. Pharmacotherapy was less effective than cognitive behavioral therapy [29, 30]. Poulsen and colleagues [31] conducted randomized studies, the results of which showed a lower efficacy of psychoanalytic therapy, despite its much longer duration, than CBT-E. In other studies, short-term psychodynamic therapy was less effective than CBT-BN [32]. Interpersonal therapy (IPT) is considered an alternative form of treatment for CBT-E but according to research, CBT-E gives better results [21] and contributes faster to the remission of bulimia symptoms [24].

The presented results prove the effectiveness of cognitive-behavioral therapy in the treatment of bulimia. It has a beneficial effect on the reduction of binge eating, purging, normalization of eating habits, reduction of excessive focus on weight, eating and figure as well as on improving self-esteem. There is also observed improvement in social functioning and limiting the severity of general psychiatric symptoms of patients. The results of therapy, measured one year after the end of treatment, persist. Cognitive-behavioral therapy is also more effective than pharmacotherapy and is the first method of choice for treatment among other therapeutic methods, except for IPT [13, 27].

Restrictions and future directions of development

The treatment model proposed by Fairburn [11] is an opportunity to help many patients. However, as he admits, it is not a panacea for everyone. One study showed [20] that 15 months after the end of treatment, 51.3% of patients with eating disorders were still experiencing high severity of eating disorder symptoms. Therefore, the priority is to further develop cognitive-behavioral therapy or to integrate it with other approaches so that as many people as possible receive effective help [13].

The observed ego-synthonicity of symptoms and ambivalent attitude to changes in patients with bulimia [33] may be an area where it is worth using Motivational Interviewing

(MI) to increase the number of people starting and continuing psychotherapy. The basis of this method is the concentration on the person and cooperation with the patient, aimed at arousing motivation to change [34]. Originally, MI was created to work with addicted people who did not want help and gave up therapy despite experiencing negative consequences of their disorder. Such a description also corresponds to patients with bulimia and is a justification for the use of MI in this group.

Preliminary results of studies on the effectiveness of MI in the treatment of people with eating disorders are promising [33]. Macdonald and colleagues [35], in their review of research on the use of MI and its interventions, showed the effectiveness of this method in increasing the readiness for changes in this group of patients. In other studies conducted among women suffering from bulimia, the effectiveness of MI was compared with CBT. Both treatments lasted four sessions and brought similar effects in reducing the intensity of the symptoms of the disorder [36]. However, this study has some limitations that pertain to a high dropout rate (46%) and a short observation period.

Miller and Rollnick [34] suggest MI integration with other therapeutic approaches, which can be a helpful solution. In the context of combining with CBT-E, there are two possibilities of using MI: as a method preceding CBT-E or during therapy, when the motivation to change decreases. In one study [37] conducted on a group of patients with eating disorders, CBT-E efficacy was compared with an MI-based intervention – Motivation-Focused Therapy (MFT) that preceded CBT-E (MFT + CBT-E). The results showed that the MFT phase itself was associated with a significant increase in readiness to change. However, the effectiveness of MFT + CBT-E compared to CBT-E was not demonstrated to be better in terms of the dropout rate and reducing symptoms of eating disorders. These are preliminary results and further research is needed in this area.

In conclusion, preliminary reports from studies have proven the validity of the use of MI. This method may help to increase motivation, determine the stage of readiness to change in patients suffering from eating disorders and adjust interventions to it. In addition, it strengthens the therapeutic relationship and motivation of the patient throughout the therapy period [33]. However, there is a need for further empirical research on the effectiveness of this method in patients with bulimia and the possibility of combining it with CBT-E.

Bulimia and borderline personality disorder (BPD) are connected with interpersonal problems and mood intolerance, which lower the effectiveness of CBT-E [10]. According to statistics, about 30% of people with bulimia have co-occurring BPD [38]. The cited facts may be an argument for using the third wave of the cognitive-behavioral therapy in this group of

patients: dialectic behavioral therapy (DBT) and schema therapy (ST), which were originally created for people with personality disorders [39, 40].

DBT has been adapted to help people with bulimia by Safer and colleagues [41]. The authors recognize that impulsive binge eating and compensatory behavior are the results of emotional dysregulation, which is a factor that maintains the disorder. The treatment consists of modules devoted to learning techniques based on mindfulness and the ability to regulate emotions and tolerate distress. As a result, patients begin to identify, understand and accept their emotions. They also gain the ability to change their emotional states and express them.

There is already some preliminary evidence of the effectiveness of DBT in the treatment of bulimia [41]. In randomized, controlled group trials [42], it turned out that DBT affects the reduction of binge eating and purging episodes. In addition, it reduces emotional dysregulation, which may provide evidence for the role of this mechanism in maintaining symptoms. However, it should be emphasized that further randomized studies involving more people are needed in this area.

A promising direction of research towards the increase of the effectiveness of bulimia treatment seems to be the use of ST. There are several arguments for this. According to empirical reports, people suffering from eating disorders also have dysfunctional beliefs unrelated to food, weight, and appearance. A higher level of early maladaptive schemas (determined by the general results of the Young Schema Questionnaire) was found in the group of people suffering from bulimia than in the control group [43]. In addition, identified risk factors for the development of bulimia nervosa are the experience of trauma, including emotional, physical and sexual abuse, neglect in the period of childhood [44]. Those may create maladaptive schemas, the treatment of which ST was created for [40].

Until now (31.08.2018), after entering the key words "schema therapy", "eating disorder", "bulimia nervosa" in the EBSCO database, only one article appeared, one study has been carried out [45] verifying the effectiveness of the group schema therapy in the treatment of eating disorders ("Group Schema Therapy for Eating Disorders", ST-Eg). Unfortunately, the sample consisted of only eight people suffering from chronic eating disorders (four had bulimia nervosa) and there was no control group, which significantly limits the possibility of generalizing the preliminary reports on the effectiveness of this method. Simpson and colleagues used specifically adapted ST for the treatment of eating disorders, which included cognitive, experiential and interpersonal techniques (e.g. limited re-parenting), with particular emphasis on behavioral change. Specific ST strategies focused on the body image, perceiving sensations from the body, and the ability to regulate emotions. The treatment consisted of 20

sessions. The results showed an average reduction in the intensity of schemas after the end of treatment by 43%, and after six months by 59% and a significant reduction in the intensity of anxiety, shame, and psychopathology of eating disorders. Further tests are also needed to verify the individual version of ST on the group of people suffering from bulimia [45].

The third wave of cognitive-behavioral therapy brings another method that can be helpful in the treatment of bulimia. Integrative Cognitive-Affective Therapy (ICAT), unlike traditional CBT-BN, puts more emphasis on interpersonal patterns, emotional experience, self-directed behavior patterns, intrapsychic factors, self-oriented cognition and cultural factors [46]. The elements described in this model are bulimia-maintaining processes and should be covered by therapy. In addition, interventions to enhance motivation for treatment, based on MI techniques, are included in ICAT [34]. Great attention is paid to emotional reactions and exposure to emotions, including food, shape, and weight. As in CBT-E, part of the therapy is to regulate eating habits, plan meals and prevent relapses [46].

Randomized studies, comparing the efficacy of CBT-E with ICAT [47] have been performed. It turned out that both methods have similar efficacy in reducing the severity of bulimia symptoms, depression and anxiety, improving emotional regulation and self-esteem. These results provide an incentive to verify the effectiveness of ICAT on a larger group of people. The option of combining CBT-E and ICAT should be taken into account in future theoretical considerations and research because the treatment stages in both methods correspond to some extent.

In conclusion, bulimia nervosa is a difficult disorder to treat [1]. Cognitive-behavioral therapy (CBT-BN and CBT-E based on it) has the best research-proven effectiveness. Therefore, it is the treatment of first choice [6] and should be offered to patients and promoted among clinicians [13]. However, it should be remembered that CBT-E also has its limitations – unfortunately, it cannot help about half of the patients [31], which indicates the need for further improvement of this method. One possibility is the integration of CBT-E with MI [34]. Another promising direction for the development of bulimia nervosa therapy, which can make more people achieve effective help, is the use of the third wave of cognitive-behavioral therapy (DBT, ICAT, and ST) in versions adapted for this group of patients. It is a priority to conduct further research in this area and to create detailed guidelines for the use of the above-described forms of therapy and MI, which could include, for example, the following factors: low level of motivation, chronicity of the disorder, problems with regulating emotions, difficult childhood experiences, impulsiveness, and co-occurring personality disorders and other general psychiatric patients' problems.

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