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Case Report

The Importance of Emotional Insight in Cognitive Behaviour Therapy for Anorexia Nervosa: An Adolescent Case Study

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Abstract

Anorexia nervosa is a rare but severe psychiatric disorder in adolescence, with chronicity and death being the most feared consequences. Emotional Insight into one's problem is considered a key determinant of success in therapy. The following case study of a 14-year-old client, describes the process of therapy as it unfolded across 45 sessions. An eclectic therapeutic approach comprising cognitive behavioural therapy along with some psychodynamic principles and supportive techniques was adapted. A lack of emotional insight was hypothesized as the missing link between an intellectual understanding of her illness and recovery from it. Process, outcome, and active therapeutic ingredients in individual therapy are described.

Key words: Anorexia nervosa, insight, cognitive behaviour therapy, resistance.

Introduction

Anorexia nervosa (AN) is characterized by a fear of increasing body weight, a fear of loss of control and an abnormal self-image [1]. The teenager often gradually recovers from the illness, but anorexia nervosa is also known for its severe complications, with chronicity and death being the two most feared consequences [2].

Intellectual insight refers to a state where the person admits there is an illness without applying it to future experiences whereas emotional insight has the additional component of awareness of the underlying meaning of the symptoms and openness to new ideas and concepts about self and the important people in the person's life [3].

The following case study described the individual therapy in an adolescent with AN, a lack of emotional insight was hypothesised as the missing link between an intellectual understanding of her illness and recovery. Intensive family therapy was also carried out, and is not the focus of this report.

The client

Ms. S is a 14-year-old girl, second of two children from a well-educated, upper socio-economic status family with a personal history of having high moral standards, minimal social interaction, and family history of ulcerative colitis in mother. She had easy pre-morbid temperament, and past history of febrile convulsion. She presented with one and half-year illness characterised by self-starvation, severe weight loss, and a strong belief that she was overweight, along with amenorrhoea. Also, she had repetitive actions such as repeatedly turning on and off light switches. She also had superstitious beliefs, for example, about certain numbers and colours being a bad omen that would fatten her. She recognized these thoughts as her own, intrusive, repetitive, excessive, irrational, distressing, but she did not try to resist them. She was admitted to child psychiatry ward.

Clinical evaluation and management

Weight on admission was 36.6 kg and Body Mass Index was 14.2. All the relevant physical investigations were normal. Yale-Brown Obsessive Compulsive Scale indicated severe obsessive compulsive disorder (OCD) with a score of 30. Beck's Depression Inventory scores indicated moderate depression (score of 27). . She was diagnosed as having AN with OCD with moderate depressive episode. Medical treatment consisted of nutritional and dietary management aimed at gradual normalization of weight. After a failed trial of sertraline, she was put on fluoxetine 60/day, with which there was a slight improvement in OCD. Olanzapine 5 mg was added later, based on occasional reports of benefit in AN. In February, 2011 she developed severe depression with a serious suicidal attempt and was switched to escitalopram 30 mg per day, olanzapine was continued, and lithium 450 mg/day was added with serum level of 0.8mE/L.

Psychopathology formulation

Beck's Cognitive-Behavioural framework was particularly relevant to conceptualize the client's problems:

Figure 1: Beck's Cognitive-Behavioural framework for the client.

Early experience

- Anxious temperament of mother
- Teasing and bullying in school, victim of statements such as 'fat girls eat so much' etc

Formation of core beliefs

- I am powerless and vulnerable
- I am defective
- I am not good enough

- Others are likely to judge and criticise me

Intermediate beliefs: attitudes rules and assumptions

- I should be able to achieve high standards; otherwise it is proof that I am not good enough
- Being able to control me eating means I am good at something and I can prove myself

Critical incident

- Change of school
- Shock and inadequate adjustment to menarche

Behaviours	Cognition	Physiological
- Restrict food - Wear heavy clothing and drink plenty of water before being weighed - Eat slowly - Press all the food to drain oil if present - Spit out food in the sink - Over boil the milk to let it evaporate to the largest extent.	- I feel bloated if I eat anything at all - I feel OK at this weight- it is hard to believe that there is anything really wrong when I feel well - Any minute variation from my weight means I have lost control, and failed as a person	- Amenorrhea - Brittle hair - Growth of fine hair all over body - getting cold easily

Process of therapy

Cognitive behavioural approach was used to work on the client's cognitive distortions. A psychodynamic stance helped to understand the client's resistances and impasses in therapy, which were dealt with using supportive therapy techniques. She was seen for 45 sessions on almost daily basis each session lasting around 1 hour. Rapport could be established, and the patient readily agreed to work with therapist for her OCD. However, she refused to enter into any discussion regarding AN.

Were obsessions and anorexia-specific cognitions separable?

A 4-column chart was prepared to obtain a better idea of the nature of her thoughts, antecedents and consequences to throw light on the thin line between obsessive thoughts and thoughts pertaining to eating. A cycle of her thought process was constructed which is as follows:

Figure 2: A cycle of thought process of the client.

Thought about 7th std (called 'old' thoughts)

Relief from undoing the effect of an old thought

Having an old thought associates her to a time when she was over-weight (57 kg)

Accompany new thought with repeating the action currently on hand, as a way of nullifying the bad thought completely.

Fear of becoming that way again

Replacing the 'old bad' thought with a current thought (new good thought) when she is light (37 kg)

This shows that a vast majority of her obsessions were ultimately linked to her repulsion against weight gain.

Exposure response prevention and cognitive restructuring for OCD

A hierarchy was constructed regarding the triggers for her obsessive thoughts and rated according to her subjective units of distress (SUD). Exposure exercises were initiated using her uniform, books etc., and concurrently cognitive work was initiated. In the sessions, a sample of her thoughts were identified and teased out to the core of the cognitive distortion. Distortions such as dichotomous thinking and thought-event fusion were identified. Socratic questions were taught to her and the process of guided discovery was initiated. Transfer of learning was encouraged in terms of helping her challenge her dysfunctional assumptions and find alternate explanations in various situations independently.

Facilitating insight into anorexia

Cognitions surrounding her fear of gaining weight were elicited. Being thin was associated with more confidence and that she 'simply loved it'. However being anything more than her current weight was equal to becoming obese. It drove her to be angry at herself for losing control and at people involved in making her put on weight. There was less confidence, shame, fear to face people and ultimately dwindling respect for herself as a person. She was able to identify her distortions. However, at this stage in therapy, she showed signs of resistance to change such as being less verbal, less pro-active in generating alternative ways of thinking and uninterested in the session. An attempt at gentle confrontation and paradoxical interventions to address the core issues such as body image disturbance led to only transient changes.

Therapy reached a point when there were not many options left, other than to face her deepest fear of gaining weight and letting go of her sense of control. She began to have periods of intense low mood and self-harm. A reassessment was done, and an increase was seen in both the Y-BOCS score and in BDI. It was hypothesized that the girl found it extremely difficult to contain her feelings of anxiety that prevented her from bringing about any change. She was discharged at this point as her weight had improved.

She was irregular on follow-ups. She was readmitted later as her clinical condition worsened. During this period, she was nearly mute and had intense anger at her mother that also spilled over to treating team. Therapist persevered with sessions in a non-judgemental and non-directive manner. After nearly 3 weeks, she was willing to talk in sessions.

In the light of her difficulty in implementing an intellectual understanding of her problems into a purposeful action, therapy shifted to a more supportive stance. Use of humour and reassurance increased her sense of mastery. A supportive stance continued, providing silences for her to come up with any issue spontaneously- a sign that she is ready to work with deeper issues. The therapy served in a way to externalize her interests by increasing her socializing experiences, hobbies and introducing activities in her life to foster a normal development as possible. Helping her transfers the nurturing and confiding relationship with the therapist to other identifiable friends was attempted as an effort to open avenues for healthy development.

Maintenance

Telephonic follow-up in January 2013 revealed that she has been doing exceedingly well at academics, her weight is borderline but stable, she has some friends, attends dance class rarely and there has been 80% improvement in her obsessive-compulsive disorder.

Discussion

Therapeutic work with this patient highlights the importance of adopting techniques from different schools of therapy to understand the stark contrast between the rate at which the

client initially grasped new information and the difficulty in implementing this understanding into meaningful action. This is the crux of emotional insight. Poor ego strength, presence of disturbed intra familial relationships and presence of co-morbid obsessive compulsive disorder limited the extent of improvement in the client.

In understanding the various factors responsible for the improvement in the client, relationship mediated factors such as empathy, warmth, recognition, affirmation and validation [4] were found to be of paramount importance. Client related factors of her being psychologically minded and having above average intelligence helped her to engage in cognitive behaviour therapy and obtain a perspective of her illness. From the therapist's perspective, the importance of keeping hopelessness and negative counter-transference in check by means of supervision is of paramount importance in dealing with such clients.

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