A Review of Eating Disorders Treatment Research

Numerous studies have shown that eating disorders are among the deadliest of all psychological disorders. One study reported that mortality rates are 4% for anorexia nervosa, 3.9% for bulimia nervosa and 5.2% for those suffering with an eating disorder not otherwise specified. However, when one figures in mortality due to complications from eating disorders (such as organ failure, depression leading to suicide, etc.) figures rise. For example, it is estimated that 15-20% of victims of anorexia nervosa die as a result of their eating disorder or related complications. Very often victims of eating disorders have other diagnoses that also require treatment (and may lead to greater risk of death). The Cleveland Clinic reports:

Common comorbid conditions include major depressive disorder or dysthymia (50% to 75%), sexual abuse (20% to 50%), obsessive-compulsive disorder (25% with anorexia nervosa), substance abuse (12% to 18% with anorexia nervosa, especially the binge–purge subtype, and 30% to 37% with bulimia nervosa), and bipolar disorder (4% to 13%).

Eating disorders are prevalent in the Orthodox Jewish community, both in Israel and the Diaspora. Dr. Jonathan Kirschner writes:

While it remains unclear whether there is a growing trend or if an increase in treatment resources has led to more people seeking help, treatment facilities, mental health practitioners, and physicians agree that eating disorders are increasingly prevalent in the Orthodox Jewish community (Peyser, C. & ATID Fellows Research Team. Body and soul: A guide for addressing eating disorders in a Jewish education setting. Jerusalem, Israel: Academy for Torah Initiatives and Directions Press, 2005.) This is particularly true for Orthodox Jewish women.

Suggestions as to why Orthodox Jews of all kinds fall victim to eating disorders vary from the same psychological reasons as in the general population, to specific reasons such as emphasis on

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food within Judaism and marriage related pressures. Studies and anecdotal reports have differed as to whether eating disorders are more or less prevalent in the Orthodox population than in the general Jewish population. Dr. Kirschner writes:

The most recent study to date was conducted by Pinhas, Heinmaa, Bryden, Bradley, & Toner (2008) and provides both new and contrasting information from previous studies. In this study, Canadian high school students (n=868) were administered the Eating Attitudes Test and a religious practice questionnaire. The researchers discovered that Jewish females (ages 13-20) endorsed significantly greater disordered eating attitudes and behaviors than non-Jewish students. Furthermore, a comparison within the Jewish group did not reveal a relationship between higher religious observance and lower eating pathology. As such, the authors concluded that Jewish adolescent females could be at higher risk for developing eating disordered pathology. These findings are in stark contrast with previous studies of American and Israeli, non-clinical samples.

Eating disorders are complex and can vary in cause. There are a number of treatment methods which have been studied that have been shown to be effective once patients are no longer in imminent physical danger (which requires hospitalization).

A recent article by Drs. Campell and Peebles of the Children’s Hospital of Philadelphia, published by the American Academy of Pediatrics, notes:

No single cause of EDs has emerged, although neurobiological and genetic predispositions are emerging as important. Recent treatment paradigms acknowledge that they are not caused by families or chosen by patients. EDs present differently in pediatric populations, and providers should have a high index of suspicion using new Diagnostic and Statistical Manual, 5th edition diagnostic criteria because early intervention can affect prognosis. Outpatient family-based treatment focused on weight restoration, reducing blame, and empowering caregivers has emerged as particularly effective; cognitive behavioral therapy, individual therapy, and higher levels of care may also be appropriate. Pharmacotherapy is useful in specific contexts. Full weight restoration is critical, often involves high-calorie diets, and must allow for continued growth and development; weight maintenance is typically inappropriate in pediatric populations. Physical, nutritional, behavioral, and psychological health are all metrics of a full recovery, and pediatric EDs have a good prognosis with appropriate care.

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6 Kirschner

It is noteworthy that no one method has been shown 100% effective for all patients. Dana Satar writes in the Renfrew Center’s Journal:

AN [anorexia nervosa] has the highest mortality of any psychiatric illness with estimates of upwards of 15 percent (Herzog et al. 2000). However, currently no treatments have been established as ‘efficacious’ for the treatment of adults with AN. This is not for lack of effort or creativity. A recent review of fifty-seven psychological treatment studies for AN (twenty-three of which were randomized controlled trials) reported that there was currently no evidence that one specialized treatment was superior to another for treating adults with this illness (Hartmann, Weber, Herpertz, & Zeeck, 2011). 8

**Family Based Treatment (the Maudsley Method):**

One increasingly popular form of treatment is Family Based Treatment, known as the Maudsley Method (after the hospital where it was developed). Family Based Treatment (FBT) assumes that parents are critical allies in the fight against their child’s eating disorders. Over a 6-12 month period, parents are taught how to help their child eat properly and to refrain from engaging in symptoms (such as purging or over exercise). Once patients have attained healthy weight, they are given more control over their own eating. At the same time, the family therapist works with the patient and family to restore normal family relationships. The patient is primarily at home, as the patient needs to learn to live a normal life. According to the Cleveland Clinic this method “has been particularly successful with shorter duration anorexia nervosa.”

When this method was studied, researchers examined the difference between results achieved in Family Based Treatment as opposed to solely Adolescent Focused Treatment (AFT). They found that

There were no differences in full remission between treatments at EOT [end of treatment]. However, at both 6 and 12 month follow-up FBT was significantly superior to AFT on this measure. FBT was significantly superior for partial remission at EOT but not at follow-up. In addition, BMI percentile at EOT was significantly superior for FBT, but this effect was not found at follow-up. Participants in FBT also had greater changes on the EDE [eating disorder examination] at EOT than those in AFT, but there were no differences at follow-up...Although both treatments led to considerable improvement and were similarly effective in producing full remission at EOT, FBT was more effective in facilitating full remission at both follow-up points. 10

Another study of younger patients (ages 9-12) noted that:

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10 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038846/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038846/)
Children with AN [anorexia nervosa] share most disordered eating behaviors with their adolescent counterparts; however, their EDE scores are significantly lower than adolescents at both pre- and post-treatment assessments. Over the course of treatment with FBT, children showed statistically and clinically significant weight gain and improvements in eating disordered thinking as measured by the EDE.  

**Cognitive Behavioral Therapy:**

Cognitive behavioral therapy is a multi-staged process that tries to provide the patient with accurate ways of thinking and then practices healthy behaviors. Patients learn about appropriately healthy eating and the dangers of various behaviors (self-imposed starvation, over exercise, over use of laxatives, etc.) and address disordered thinking (such as “feeling fat”). Patients may eat with the therapist. Regular weigh-ins are part of treatment. Regular meal plans are established. Family members are involved in treatment. Dr. Glenn Waller wrote in the Renfrew Center’s journal:

> There is evidence that early behavioral change is a key determinant of later progress in different therapies for the eating disorders (e.g., Agras, Crow, Halmi, Mitchell, Wilson & Kraemer, 2000; Doyle, Le Grange, Loeb, Doyle & Crosby, 2010; Wilson, Loeb, Walsh, Labouvie, Petkova, Liu & Waternaux, 1999), so be firm about the need to change from very early on – give the patient a choice about having the best chance to get well.  

As treatment continues, progress is evaluated. Issues behind the disorder, such as overemphasis on weight, low self-esteem and perfectionism, are addressed. Self-imposed rules about eating are examined and hopefully eliminated. Finally, the patient works to develop plans for the future.

CBT is also a primary treatment for patients with obsessive compulsive disorder, which often is comorbid with eating disorders.

Cognitive Behavioral Therapy has been found to be effective, particularly in the treatment of bulimia. Dr. Laura Choate wrote in the Renfrew Center’s Journal:

> CBT has emerged as the gold standard treatment model for understanding and treating eating disorders (APA, 2006; Wilson, Grilo, & Vitousek, 2007) and there is evidence that clients experiencing EDNOS [eating disorders not otherwise specified] will respond well to an adaptation of CBT (Wilson et al., 2007).

Dr. Moriah Golan, Director of the Shahaf Institute, reported that CBT is highly effective when combined with family therapy.

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12 [http://renfrewcenter.com/sites/default/files/Perspectives%20Summer%202012.pdf](http://renfrewcenter.com/sites/default/files/Perspectives%20Summer%202012.pdf)
13 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928448/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2928448/)
14 [http://renfrewcenter.com/sites/default/files/Perspectives%20Summer%202012.pdf](http://renfrewcenter.com/sites/default/files/Perspectives%20Summer%202012.pdf)
Most experts agree that, outpatient family therapy and CBT are first-line treatments for patients with EDs whose duration of illness has been brief. Severe eating disorders often require a comprehensive and longer intervention. Fairburn et al. reported that a transdiagnostic CBT appeared to be suitable for the majority of outpatients with an ED. They found that patients with complex psychopathology responded better to CBT that addressed the following maintaining factors: marked mood intolerance, clinical perfectionism, low self-esteem, or interpersonal difficulties.  

*Interpersonal Psychotherapy*

*Interpersonal Psychology (IPT)* is short term psychotherapy (up to 20 sessions) that focuses on interpersonal issues, which are presumed to have led to the current psychological difficulties. The goal is to resolve symptoms, improve interpersonal relationships and increase social support for the patient. 

Drs. Champion and Power from Oxford University note that IPT is often appropriate since:

“Interpersonal difficulties are common in patients with eating disorders and they appear to contribute to their maintenance. These difficulties may predate the eating disorder or they may have a more recent onset and indeed be a consequence of the disorder… Many patients have had limited experience developing and maintaining intimate relationships, partly as a result of social withdrawal that is a common feature of eating disorders but also due to the low self-esteem which often accompanies the disorder.”  

A study from the University of Leicester showed that IPT was effective in treating bulimia nervosa, though could take longer than CBT. This was particularly the case when the following elements were used: psychoeducation, directive techniques, problem solving, modelling, role play and symptom review. A study from Oxford University also showed IPT to be effective in the treatment of bulimia. There have not been conclusive studies of the impact of IPT on those suffering with anorexia.

*Art Therapy*

Art therapy is often used as part of treatment of eating disorders. As an art therapist at Singapore General Hospital wrote:

> Art therapy can be a valuable tool in the recovery process of individuals with eating disorders. It can be introduced as an alternative coping skill where patients are

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15 *Journal of Eating Disorders* 2013, 1:19 doi:10.1186/2050-2974-1-19. The electronic version of this article is the complete one and can be found online at: [http://www.jeatdisord.com/content/1/1/19](http://www.jeatdisord.com/content/1/1/19).


encouraged to creatively express difficult and overwhelming feelings and emotions that are otherwise expressed through the control of food. Art therapy gives form to feelings, concerns, and stress which can be understood and addressed.\textsuperscript{21}

In one survey, 19 residential eating disorders treatment centers reported using art therapy as part of overall treatment. However, there were no studies conducted as to its effectiveness.\textsuperscript{22} The Renfrew Center is one well known treatment facility that includes art therapy.\textsuperscript{23} One former patient wrote, “Art therapy was especially therapeutic for me when words were so hard. Creating art allowed me to sort out the issues that lead me there as well as discover more about myself in the present.”\textsuperscript{24} The American Art Therapy Association reports that art therapy has been shown to be effective as it promotes greater self awareness and provides an important emotional outlet.\textsuperscript{25}

\textit{A Multi-Disciplinary Approach}

Dr. Golan writes of the critical importance of having a multi-disciplinary team that works together with a patient to battle the eating disorder. She writes:

The complexity of EDs calls for a collaborative approach by a multidisciplinary team of mental health, nutrition, and medical specialists. Since co-morbidity for patients with EDs is the rule rather than the exception, recommendations emphasize the importance of specialized care for the treatment of EDs, as well as an intervention model that approaches illnesses from a transdiagnostic orientation, which addresses the dynamics and needs of co-morbidities while treating the ED effectively …

Treatment duration ranged between 15 months to four years. At the end of treatment 69\% of those diagnosed with AN and 81\% of those diagnosed with BN [bulimia nervosa] were in a fully recovered state or much improved. “Fully recovered” was defined as full remission lasting more than 12 months. “Much improved” was defined as partial remission, with infrequent occurrence of the symptoms as well as full occupational and social functioning. All the recovered patients terminated the treatment with mutual consent. Those who were much improved declined regular care and only attended follow-up sessions.

The key to providing quality care for people with EDs and co-morbidities is to coordinate the effort and recommendations of each member of the multidisciplinary team of mental health, nutrition, and medical specialists, who are often unilaterally involved in the initial

\textsuperscript{22} http://www.ncbi.nlm.nih.gov/pubmed/16777810
\textsuperscript{23} http://renfrewcenter.com/services/experiential-therapy
\textsuperscript{24} http://renfrewcenter.com/for-you/patient-testimonials
\textsuperscript{25} http://www.americanarttherapyassociation.org/EatingDisorderToolkit/eatingdisorderstoolkit.pdf
evaluation and subsequent treatment. This is done with a collaborative approach. Such multidisciplinary networks may vary by healthcare setting and/or by country. However, the use of a multidisciplinary approach allows diagnostic conclusions and the subsequent plan for treatment to reflect the input and collaboration of the multiple disciplines and centralization of documentation related to the initial evaluation and treatment reports. Such coordinated multidisciplinary care can influence the course of EDs. The way in which physical and mental health services work together is arguably one of the most important elements of effective care. To that end, a shared understanding of EDs is essential.26

Dr. Golan suggests that “narrative therapy,” combined with other treatments, can be quite helpful in assisting patients with eating disorders.

Narrative therapy challenges the idea that expert knowledge belongs to the world of therapists and the medical model. It challenges the truths and alleged objectivity of these disciplines, instead taking up the ethic of collaboration and engaging in the practice of “co-research” (Epston, 1991, 2001). It explores factors that have contributed to the meanings the person has constructed about his/her life and experiences and identifies the person’s knowledge about the influence of his/her eating disorder on his/her life. It also identifies knowledge about factors supporting or undermining that influence. The counselor explores unique ways in which eating disorder patients resist and challenge problematic behaviors we call “pro-eating disorders steps,” such as eating less or deciding not to join friends because of eating or mood issues (Lock, et al., 2005)....

In order to counter the patient's resistance to change and the power struggle that often occurs when treating eating disorders, the narrative language (White & Epston, 1989) is utilized toward treating symptoms. During narrative conversations, AN and BN are externalized, and people are encouraged to identify the ways in which the eating disorder has taken over their lives (e.g., via isolation, physical and emotional disappearance, engagement in self-policing, empty promises, etc.). The therapists then enlist patients to form a coalition against the illness to regain freedom, engaging in change rather than guilt or blame, which are often the dominant feelings among patients with eating disorders (Grieves, 1997). Treatment integrates narrative therapy, motivational intervening, dialectic behavior therapy, cognitive-behavioral therapy, bio–feedback, and dynamic approaches. Psychosocial interventions are chosen on the basis of a comprehensive evaluation of the individual patient, considering cognitive and psychological development, psychodynamic issues, cognitive style, comorbid psychopathology, patient preferences, and family situation. Thus, different pathologies receive different treatment strategies, but the conversation is always a collaborative, generative process mutually constructed between the therapist and the people seeking help. 27

26 ibid
Evaluation of Success of Treatment

It is clear from the research that we have reviewed that evaluating success of treatment (both of a specific patient and of a group receiving a particular type of treatment) is a challenge. Studies have not necessarily been consistent in method.28 Ideally, one should evaluate a patient’s health at the end of treatment, as well as six months and twelve months after treatment. However, patients are not always open to further evaluation.

In addition, it is not always clear what success looks like. For example, it is likely an unrealistic expectation for someone with an eating disorder to be forever cured of all symptoms and disordered thoughts.

Nonetheless, there are some areas that researchers are able to consider in determining success of treatment. For example, Dr. Golan (in the passage quoted above) offers the following definitions.

“Fully recovered” was defined as full remission lasting more than 12 months.

“Much improved” was defined as partial remission, with infrequent occurrence of the symptoms as well as full occupational and social functioning. 29

In addition, researchers have looked at whether patients after treatment maintain a healthy weight and are no longer engaged in self-destructive behaviors.

Mercaz Female’s Approach

Mercaz Female’s staff continues to have intensive training from Dr. Moriah Golan and her staff at the Shahaf Institute. As such, its approach is heavily influenced by her proven techniques.

Mercaz Female has an interdisciplinary, team approach. A patient’s entire team (physician, therapist, dietitian, mentor) work together closely. Close contact is maintained with any outside professionals involved (such as family physicians or psychiatrists). This is particularly important with patients who have other diagnoses and/or are on medication as part of treatment.

As with Family Based Therapy, parents are involved in their child’s treatment as weekly sessions are required. This is a critical part of treatment as no matter the kind of therapy, it is clear that parents need guidance in to how to assist in the child’s recovery. Patients’ individual therapy is in accordance with their needs. Therefore, some receive art therapy, while others’ therapy is primarily CBT or narrative. Other methods (e.g. analytical psychology, which explores patients’ prior experiences, attitudes and challenges that may have led to their current difficulties30) are used based on patient needs. There is certainly the opportunity to explore interpersonal issues, particularly since patients are living at home and are generally attending school or employed. In

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29 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3886290/#b23
30 http://www.mirror-mirror.org/cognitive-analytic-therapy-eating-disorders.htm
every case, treatment is- to use Dr. Golan’s words- “a collaborative, generative process mutually constructed between the therapist and the people seeking help.”

As a specifically Orthodox center, Mercaz Female is able to include a spiritual and values-centered dimension in its work with patients. This has clinical benefit. Dr. Francine Pollack (a psychologist in Philadelphia who serves on Mercaz Female’s board and provided generous assistance for this literature review) noted, “Often finding something else that is important to them, can help them to let go of the disorder.” Values, which can include religious values, are important for fighting eating disorders. Therefore, it’s important for patients to get in touch with what’s really important to them in order to replace the eating disorder with helpful and healthy values.31

Patient progress is evaluated using a protocol developed by our Clinical Director and psychologist, with input from Dr. Golan. It is an outcomes based protocol that tracks progress in various domains (physical, emotional, interpersonal and in reduction of symptoms).

In summary, Mercaz Female’s work is client-centered and follows best practices in the treatment of eating disorders. It is also providing vital services to a community very much in need of its help.